Transitions in Care

Nova Scotia Department of Health
Facilities Review

Summary

Prepared for:
the Honourable Jamie Muir
Minister of Health

March 2000

NOVA SCOTIA
Department of Health

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The full text of "Transitions in Care Report" is available in two volumes entitled:

"Volume 1 – Review of Acute Care"
and
"Volume 2 – Review of Nursing Home Beds"

Acknowledgments

The Nova Scotia Department of Health would like to thank all those individuals throughout the province who participated in the Health Facilities Review.

We are grateful to the Regional Health Boards, the Non-Designated Organizations, individual hospitals and Long Term Care Facilities (Nursing Homes and Homes for the Aged) who were engaged in the process. In particular, we would like to recognize those individuals who shared their knowledge, experience and wisdom with us in the process.

Special recognition must go to Elizabeth Barker, David Chadwick, David Elliott, Barbara Harvie, Pauline MacDonald and Wade Were from the Nova Scotia Department of Health, whose individual contributions were invaluable in the development of the methodology and the completion of this report.

This Review will contribute significantly to the future policy development for the health system, particularly in relation to "alternate levels of care" and to ensuring that care is provided in "the right place by the right caregiver."

Introduction

Upon assuming office in mid 1999, the Nova Scotia government promised that it would, "in partnership with health care providers, immediately undertake a comprehensive assessment of all health care facilities in order to ensure that Nova Scotians are receiving the right type of care in the appropriate facility." This commitment was made in response to significant concerns about the apparently high numbers of patients in the province occupying acute care beds but requiring a different level of care.

Background

Health care practices in hospitals have changed dramatically in recent years, with profound effects on the health care system. Newer (less invasive) surgical techniques, technological advances, improved anaesthesia and advances in pharmaceuticals have contributed to earlier interventions, shorter lengths of hospital stay and more rapid recovery for patients. However, like other Canadian provinces, Nova Scotia is challenged by a scarcity of resources, increased funding demands from competing social programs and internal cost pressures on the health care system. Medical advances, shifting demographics, increased public expectations and financial constraints are placing enormous pressures on hospitals to provide services differently and to do so within available resources.

Nova Scotia provides hospital care to residents of the province and, in certain cases, residents of Prince Edward Island, Newfoundland and New Brunswick. All eligible residents of Nova Scotia are entitled to receive insured hospital services under the terms and conditions of the Hospitals' Act. Hospitals in Nova Scotia offer services through a wide array of out-patient/ambulatory clinics as well as through 3,135 in-patient beds, distributed over 37 acute care facilities.

Between 1991/92 and 1999/00, the number of hospital beds in Nova Scotia declined by 37%, from 5,149 beds to 3,135 beds. Because hospital beds are a very expensive resource, health care administrators, planners and professionals must, more than ever, make sure that these beds are used as efficiently as possible, so that they benefit all who need this level of care. The hospital sector, therefore, depends heavily on strong linkages with primary care providers, the Long Term Care (LTC) and Home Care (HC) sectors.

Nova Scotia provides Long Term Care services through a variety of programs under the Departments of Health and Community Services. In part, Nova Scotia provides Long Term Care services through 5,832 licensed beds, distributed throughout 70 Nursing Homes and Homes for the Aged (referred to in the remainder of this document as Nursing Homes), plus an additional 82 beds designated for short respite stays. Twenty-two of these homes are municipally owned, 20 are private-for-profit, 7 are based in hospitals and the remaining 21 are non-profit charitable organizations.

Unlike hospital services, Nursing Home services are not fully insured. Residents who are financially able to pay the "per diem" charges do so (approximately 21% of residents). The remaining residents receive a financial subsidy from the Department of Health.

The Province provides home care services to residents of Nova Scotia through Home Care Nova Scotia (HCNS). The core services provided by HCNS are home support, personal care, nursing, home oxygen, family relief/respite and referral/linkage to community-based services. These services are administered by the Department of Health and delivered by a province-wide network of service providers. Although, currently, there are no fees for nursing services provided through HCNS, fees are charged, depending on the client's income, for the remaining services. Access to HCNS is determined through an assessment process which reviews the client's clinical condition and financial circumstances.

Review

The Nova Scotia Department of Health assembled a project team to undertake a comprehensive assessment of the use of health facilities. For the purpose of the review, "health facilities" was interpreted to include both hospitals and Nursing Homes. However, it quickly became apparent that two separate but parallel approaches would be needed to address the broad scope of the review — one to review the hospital sector and the other separately to address the issues in the nursing home sector. As a Continuing Care initiative was reviewing many reports which have been tabled in recent years, the Facilities Review Team considered that these reports would provide sufficient information for the Long Term Care segment of the review.

As part of their initial "diagnostic" phase of inquiry, the Acute Care team first examined existing reports from the hospitals and the Regional Health Boards. However, the reviewers soon concluded that there was no common utilization management tool in use across all hospitals in the province to provide the data essential for informed decision-making. The team faced the challenge of developing their own survey tool for the review.

Despite the limitations of the existing reports, the team concluded that hospitals were very likely to be providing a substantial amount of "non-acute care." This assumption was supported by a number of previous sources including preliminary feedback from a prior "across the province" physicians' consultation process in October 1999 and two (2) earlier reports (QEII Health Sciences Centre, *1997;* Cape Breton Health Care Complex, *August 1999*).

The team developed a questionnaire, focusing their efforts on specific areas believed to delay patients' timely and appropriate access to "non-acute" care (such as Long Term Care, Home Care and care in the community). With the active support and involvement of many service providers across the province, the team designed a survey instrument that would gather basic demographics on all patients, in hospitals throughout Nova Scotia, who no longer required acute care but were awaiting transition to another level of care. The sampling strategy was

an "exit survey" of the total population of the target group completed at the time of patient discharge. The survey, conducted over a two-week time period, also included patients who met the inclusion criteria but were still in hospital on the last survey day.

Many of the hospitals had prior operational commitments which prevented the review from taking place concurrently in all hospitals across the province. As a result, all hospitals in Nova Scotia provided a "snapshot" of their patient population (meeting the selection criteria for inclusion in the review) during any consecutive two-week period between **November 9, 1999** and **December 6, 1999.**

Findings

The results confirmed many of the team's and the service providers' assumptions. The Review showed that, on average, approximately **25%** of hospital patient days across the province, at the time of the survey, were for reasons other than active "acute" care *(Figure 1)*.

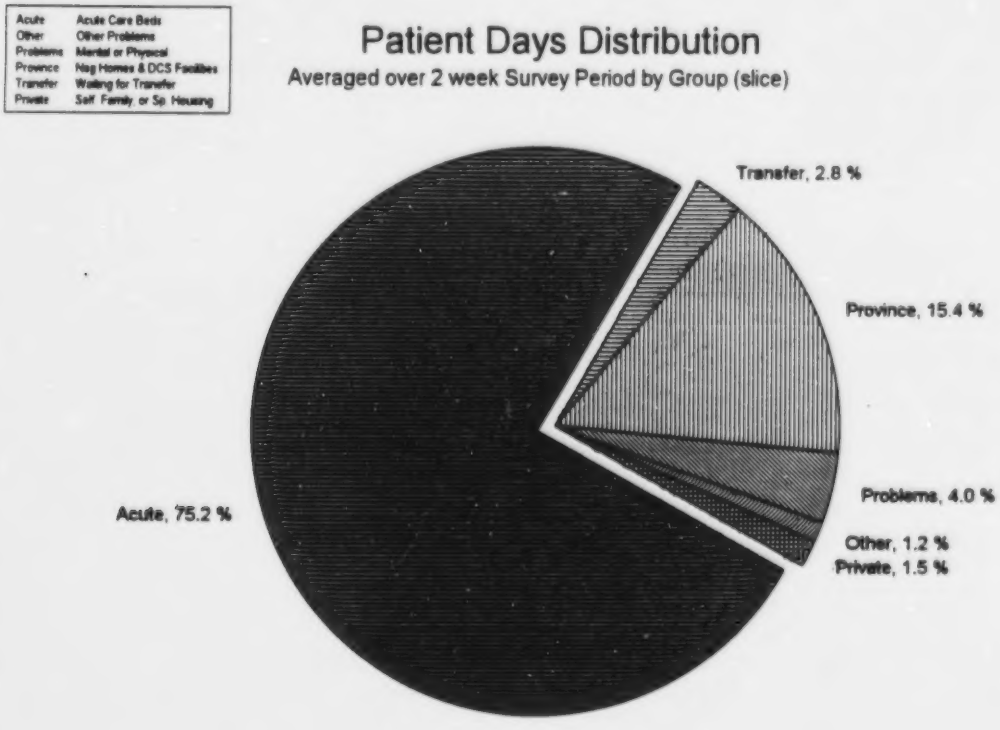

Figure 1

The results for the regions ranged from **18.9% (Central Region)** to **37.8% (Eastern Region)** for "**non-acute**" days *(Figure 2)*.

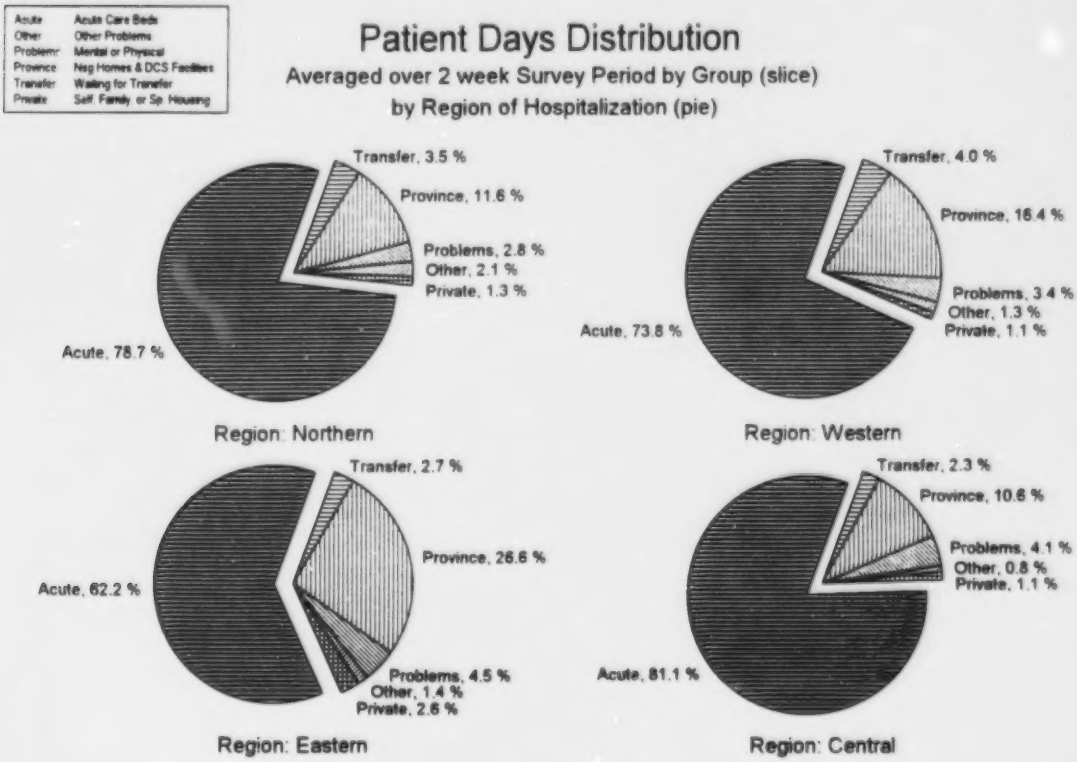

Figure 2

The single largest barrier to timely and appropriate discharge lay in patients' access to Long Term Care beds. Only a small number of "non-acute" patient days were attributed to waits for home care services. Other factors contributing to delays in discharge from acute care were "waiting for transfer," problems with access to care at home or in the community, and family-related issues. A simultaneous review of available documentation in the Long Term Care sector showed a high demand for Long Term Care beds, high occupancy rates (99%) and increasing care needs of residents.

Recommendations

This review focused on the apparent barriers to discharge from hospital for patients who could more appropriately have been cared for in another setting. The survey tool provided a "snapshot" or "environmental scan" of the problem over one unique period of time. The review did not address issues around inappropriate hospital admission.

Nevertheless, some very important information emerged. The review showed that a significant proportion of acute care bed days were attributable to patients who did not strictly need an acute level of care. This provided the hard evidence to support the views frequently expressed by many professionals in the acute care sector. While some of the acute care bed days may potentially be amenable to process improvements or more efficient throughput, much of it reflects a lack of alternative care locations.

The analysis of the LTC sector demonstrated that there was very little flexibility within that jurisdiction. Occupancy rates in Nursing Homes are consistently high, there is a strong demand for beds and residents' care needs have stretched the capacity of the LTC sector.

The combined effect of these forces has contributed to a "gridlock" in both the acute and LTC sectors of care.

With these thoughts in mind, the Facilities Review team offered the following recommendations.

Recommendation #1
The Department of Health should establish a province-wide approach to utilization management and review, using recognized, validated tool(s) to allow comparison of practices across hospitals in Nova Scotia.

- There is a wide variation in the utilization activities and measures used in hospitals in Nova Scotia, ranging from ongoing use of a recognized tool to no measurement. The province cannot make direct comparisons of performance due to the absence of complete and uniform information.

Recommendation #2
The Department of Health should establish a comprehensive, province-wide information system(s) to support meaningful, accurate reporting on performance.

- The consistency of reporting by hospitals to the Department of Health varies markedly across the province. Currently, there are no data on expenditures; no measures to determine efficiency in areas such as workload measurement, productivity, cost per service; no standing provincial requirements for reporting with the exception of the Discharge Abstract Database.

Recommendation #3
The Department of Health should establish a working group to identify the underlying cause of transfer delays to ensure a more efficient transfer of patients between facilities for acute care testing and interventions.

- Hospitals experience delays in transferring patients both prior to, and following, interventions. Currently, there do not appear to be effective mechanisms/processes that would allow for more efficient transfers.

Recommendation #4
The Department of Health should enter into discussions with the Department of Community Services to address the needs of mental health patients in the community.

- Many patients, especially Mental Health patients, remain in acute care beds because there are no facilities in the community to meet their needs. These patients do not require the services currently provided by Nursing Homes but do have specialized needs. This problem has drawn considerable attention over the past few years.

Recommendation #5
The Department of Health should continue with the current plan to implement the single-entry system of assessment, placement and case-management as a priority issue. The Community Care Branch of the Department of Health should establish a working group to address the process issues and streamline the eligibility and admission process. It is essential that the acute care sector is a meaningful partner in this process.

- The process for determining eligibility and admission to nursing homes is complicated and lengthy. Process issues account for many delays. The Department of Health has long been aware of these issues and is in the process of developing a plan for a single-entry system of access that will streamline intake, assessment, placement and case-management functions, based on priority of identified needs.

Recommendation #6
The Community Care Branch (Department of Health) should (a) ensure that the demonstration project for the Resident Assessment Instrument and its associated case mix classification system (called the Resource Utilization Grouping System) proceeds as planned and (b) begin the development of a Nursing Home finance system capable of utilizing the Resource Utilization Grouping System's case mix classification data.

- The system of funding Nursing Homes does not adequately recognize the variable care requirements of residents. A disincentive exists for Nursing Homes to accept applicants with higher care needs. The Resource Utilization Grouping System (RUG-III) represents the leading edge in case mix classification systems for long term care facilities.

Recommendation #7

The Department of Health should establish specially designated "Heavy Care" beds in the province and should convene a working group to look at the location of beds, staffing requirements, access and related policy issues. As the Single Entry Access and RUG-III system approaches proceed, the Department should ensure that the Acute Care and Community Care sectors collaborate closely to ensure that the care needs of this population are appropriately addressed.

- The current system does not provide care for patients with exceptional, specialized chronic care or for clients with high care needs. As a result, many of these patients remain in acute care beds for an indefinite length of time as their needs exceed the services currently offered in Level 2 Nursing Homes.

Recommendation # 8

The Departments of Health and Community Services should ensure the integration of their two Departments as they relate to Continuing Care. The first step in this process may be achieved through the development of an agenda of specific integration issues.

- In Nova Scotia, the Departments of Health and Community Services are accountable for the majority of publicly-funded continuing care services. There is no structured integrating mechanism between the departments to plan and manage these services.

Recommendation #9

(a) The province of Nova Scotia should invest in community-based continuing care services such as adult day, respite, community occupational and physiotherapy services, and explore different models of facility-based care. Input from communities regarding their needs and capacity is essential.

(b) Planning for all these program components should be done within the context of, and in relation to, all continuing care components and developments in other program areas such as palliative care and geriatric assessment programs.

(c) New Nursing Home beds should only be considered within the context of the outcomes accruing from other system refinements such as Single Entry Access, enhanced home care services.

(d) The Department of Health should develop "Bed Planning Guidelines" for the allocation of any new licensed Nursing Home beds. The work of the (now disbanded) Long Term Care Working Group's Subgroup on Bed Planning Guidelines should be incorporated into the guidelines.

- Single Entry Access (SEA) will provide client information useful for planning continuing care services. There is an international trend towards a declining focus on building institutions and an increasing focus on supporting people in their own homes until this

approach becomes cost-**ineffective**. Community-based alternatives remain under-developed in Nova Scotia. Caution should be taken when planning the expansion of continuing care services such as Nursing Homes, as the increasing pressures do not necessarily translate into a need for more Nursing Home beds.

Recommendation #10
The Department of Health should introduce a policy requiring all Nursing Home applicants, regardless of their ability to pay, to be screened using the same method to ensure that their care needs are consistent with the services offered by Nursing Homes. Concurrent with the introduction of this policy, the Department of Health should collaborate with the Nursing Home sector to develop a province-wide wait-list management policy and information system.

- Implementation of a single-entry system will take time and immediate action is needed to alleviate some of the problems.

Additional Considerations

1. A number of hospitals in Nova Scotia have established "transitional care" or "sub-acute care" units, based on entry and discharge criteria specific to the hospital. The result has been inequities in the provision of insured services throughout the province. The Department of Health should immediately establish a clinical program planning working group, with representation from the medical community, to develop clear clinical guidelines on access and discharge criteria to "sub-acute" and "transitional" care services pro vided by some hospitals. This group should also recommend on the policies, terms and conditions which should prevail making specific reference to the insurability (or otherwise) provisions for these services.

2. A number of the delays in discharges to home may potentially be avoided by careful advance preplanning through early referral. Examples of this would be when ensuring modifications to the home, scheduling of family vacations and arrangements for home care services.

3. There is no process in place to address funding for the special equipment, drugs and supplies the patient may require for discharge. The Departments of Health and Community Services have a shared responsibility to address these funding issues which can often result in delays in discharge for patients.

Conclusion

While the main problem may appear to be a shortage of LTC beds, this answer is simplistic. In other provinces, the introduction of a Single Entry Access system and a consistently applied eligibility policy have resulted in an actual reduction in the need for nursing home beds. However, the results of system improvements of this kind are not realized immediately and take many months before the effects are felt.

The Working Group offers a word of caution. The relationship between quality of care and system efficiency is a delicate balancing act. Any sudden shift or change in the way services are provided in one sector of health care may have a profound effect elsewhere in the system, either in terms of increased costs or diminished quality of patient/resident care. The end result may increase costs rather than the reverse. Community-specific solutions are essential to achieve the desired results.

The province of Nova Scotia is already moving ahead with plans to introduce Single Entry Access and a consistent eligibility policy. It may not be the most efficient use of existing resources at this time to embark upon a major expansion of Nursing Home bed capacity throughout the province. More readily apparent is the over-riding need to assist patients with multi-system, heavy-care requirements and exceptional care needs that are difficult to meet in the present system.

The Review Team does not necessarily recommend "new nursing home beds" at this time. However, we recognize that the Health system faces immediate challenges in meeting the care needs of many individuals currently awaiting alternative levels of care. We suggest that the provincial home care program may be well placed to offer a flexible, cost-effective option for mobilizing some of the resources needed for this particular population. Together with the judicious use of existing hospital bed "stock," these solutions may provide the province of Nova Scotia with a viable, interim answer to the serious challenges that we face today.

Transitions in Care

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Facilities Review Team

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1. Introduction

The Nova Scotia Government promised, upon assuming office, that it would:

> *"In partnership with health care providers, immediately undertake a comprehensive assessment of all health care facilities in order to ensure that Nova Scotians are receiving the right type of care in the appropriate facility."*

This initiative was seen as a key step towards developing, over time, a more cost-effective system of service delivery — a system that would ensure Nova Scotians receive the necessary care, in the most appropriate setting and in a timely manner.

Context for Review

Health care practices in hospitals have changed dramatically in recent years, with profound effects on the health care system as a whole. Newer (less invasive) surgical techniques, technological advances, improved anaesthesia and advances in pharmaceuticals have contributed to earlier interventions, shorter lengths of hospital stay and more rapid recovery for patients. However, like other Canadian provinces, Nova Scotia is challenged by a scarcity of resources, increased funding demands from competing social programs and internal cost pressures on the health care system. Medical advances, shifting demographics, increased public expectations and financial constraints are placing enormous pressures on hospitals to provide services differently and to do so within available resources.

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Between 1991/92 and 1999/00, the number of hospital beds in Nova Scotia declined by 37%, from 5,149 beds to 3,135 beds. Because hospital beds are a very expensive resource, health care administrators, planners and professionals must, more than ever, make sure that these beds are used as efficiently as possible, so that they benefit all who need this level of care.

The aim of the health system is to provide an integrated continuum of programs and services to those in need of care. The hospital sector, therefore, depends heavily on strong linkages with primary care providers, the Long Term Care (LTC) and Home Care (HC) sectors.

Nova Scotia provides Long Term Care services through a variety of programs under the Departments of Health and Community Services. In part, Nova Scotia provides Long Term Care services through 5,832 licensed beds, distributed throughout 70 Nursing Homes and Homes for the Aged (referred to in the remainder of this document as Nursing Homes) , plus an additional 82 beds designated for short respite stays. Twenty-two of these homes are municipally owned, 20 are private-for-profit, 7 are based in hospitals and the remaining 21 are non-profit charitable

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1. Review of Hospital Sector

The team drew on both qualitative and quantitative information for their review of the Hospital sector, which unfolded in a thoughtful, two-phased approach.

Phase 1

Review of Existing reports

As part of their initial "diagnostic" phase of inquiry, the hospital sector team first examined existing reports from the hospitals and the Regional Health Boards. Although these documents provided a broad range of information, they demonstrated clearly that there was little consistency in the methods of reporting and the range of indicators currently in use. The existing reports, used to monitor the appropriateness of bed utilization, were facility specific and not generalizable across the province. Also, the level of information available through the Department of Health itself proved inadequate for the specific purpose of the review. Since 1995/96, with the elimination of the former Management Information System (MIS), the Department of Health's capacity to produce province-wide reports had been reduced, resulting particularly in a lack of current provincial indicators on workload and cost per unit of service.

Based on their analysis of existing information, the review team concluded that the available reports were of greater value to the individual facilities than they were to a meaningful analysis of the system as a whole. The challenge, therefore, was to clearly define the scope of the review and to develop a standard approach to collecting the necessary information.

Development of Approach

A key assumption was that hospitals were very likely to be providing a substantial amount of "non-acute" care. At any time, a proportion of a hospital's patient population will no longer require acute care services and may be considered to be "in transition" to another level or location of care. This was supported by previous information from the Cape Breton Healthcare Complex (CBHC) *(Annex # 1, Appendix 2)*, a study undertaken at QEII Health Sciences Centre(QEII) in April 1997 *(Annex # 1, Appendix 3)* and the judgement of the 34 Chiefs of Staff or Presidents of Medical Staff who offered feedback during a province-wide physician consultation initiative in October 1999 *(Annex # 2)*.

Information provided by CBHC had identified that, during August 1999, 60% of the facility's "non-acute patient days" could be attributed to individuals

- awaiting assessment, or placement, in a Long Term Care (LTC) facility
- awaiting assessment for, or discharge to, home care services
- not requiring the level of care provided by a hospital but whose care needs exceeded the level of service usually provided by a LTC facility.

This provided further confirmation of an earlier study from 1997 at the QEII which showed that over half of the "potentially avoidable days" were related to problems with access to external resources.

The review team, therefore, focused their attention on the three (3) major problem areas identified by the QEII and CBHC as delaying patients' timely and appropriate access to alternative levels of care following hospitalization. There were patients whose discharge planning process had started, who were "in the queue" and who were approved either for home care or long term care services.

This included those who had been deemed "eligible" (following assessment) for either of these programs but were waiting for a space in the program. A second group were those individuals who may have refused an offer of placement in the community for a variety of reasons. Finally, there were those who, for reasons of mental or physical health problems, required a chronic high level of maintenance care and were judged to be unsuited for placement in the community, given current options and resources.

The team developed a questionnaire, designed to gather basic patient demographics and to capture details of situations where patients in hospital beds were awaiting transition to another level of care such as *(please refer to Annex # 3 for details)*:

- transfer (before or after receiving services)
- entry to a provincial program (Long Term Care, Home Care)
- Private arrangements (family, self-care, special housing, etc.)
- specific health problems (physical, mental)
- other

Central to the interpretation of the information captured by the questionnaire were details of bed availability and bed utilization data during the entire period of the month-long provincial study.

The team consulted with a number of external groups during the development of the tool and "pre-tested" the survey instrument at the CBHC. This contributed to a further refining of the questionnaire prior to its application across the province. A full report on this first Phase of the hospital review is provided in *Annex # 1.*

Phase II

The second Phase of the Review took place between November 9th and December 6th 1999. During this time, every hospital in the province provided a two-week survey "snapshot," in an attempt to identify the various obstacles patients faced when making transitions to different levels of care.

The sampling strategy used was an exit survey of the total population of the target group, completed at the time of patient discharge, over a fourteen day period. The survey also included patients who met the inclusion criteria but were still in hospital on the last survey day. The survey instrument was administered by hospital staff who, with the exception of one region, had attended one of eleven in-person workshops on the use of the survey tool, given by members of the review team. One region chose to receive their instructions by telephone conference call. Also, during the survey period, members of the team were available to surveyors at all times via a "help-line."

The information from the review was both **quantitative** and **qualitative** in nature.

Quantitative Findings

The Department of Health received 873 surveys from the hospital sector, of which 811 complied with the inclusion criteria. The team followed up on any errors or omissions by telephone either with the site coordinator or the person who had completed the questionnaire.

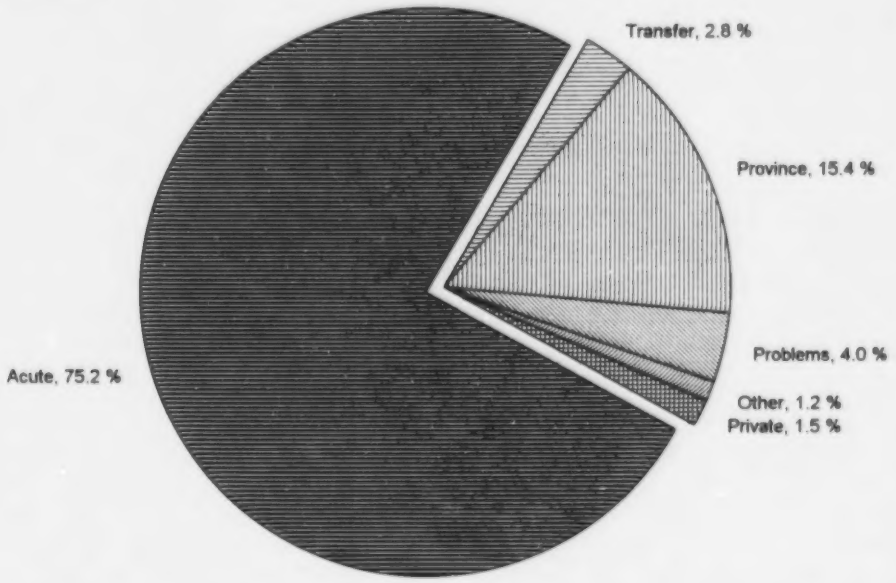
When the data was averaged over a two-week survey period, it showed that almost 25% of hospital patient days across the province could be attributed to patients with other than strictly "acute care" needs *(Annex #3, Figure 3.1)*. The distribution of bed-days by region *(Annex #3, Figure 3.2)* showed that between 18.9% (Central Region) and 37.8% (Eastern Region) of bed days in Nova Scotia hospitals, during the review period, were attributable to individuals requiring services other than acute care.

Of this group, only a small number of patient days were used by patients awaiting home care services. The largest contributor to "non-acute" care days in all regions was the group waiting for nursing home placements. A clear example is seen in Eastern Region, where the nursing home group accounted for more patient days than the other groups *(Annex #3, Figure 3.3)*.

Acute	Acute Care Beds
Other	Other Problems
Problems	Mental or Physical
Province	Nsg Homes & DCS Facilities
Transfer	Waiting for Transfer
Private	Self, Family, or Sp. Housing

Patient Days Distribution

Averaged over 2 week Survey Period by Group (slice)



(Annex #3, Figure 3.1)

Acute	Acute Care Beds
Other	Other Problems
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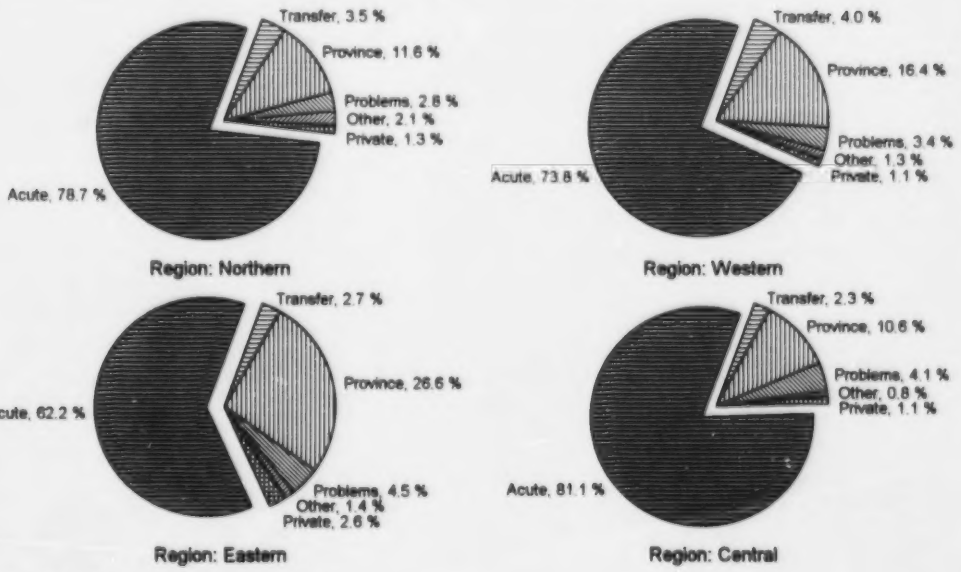
Patient Days Distribution

Averaged over 2 week Survey Period by Group (slice)
by Region of Hospitalization (pie)



(Annex #3, Figure 3.3)

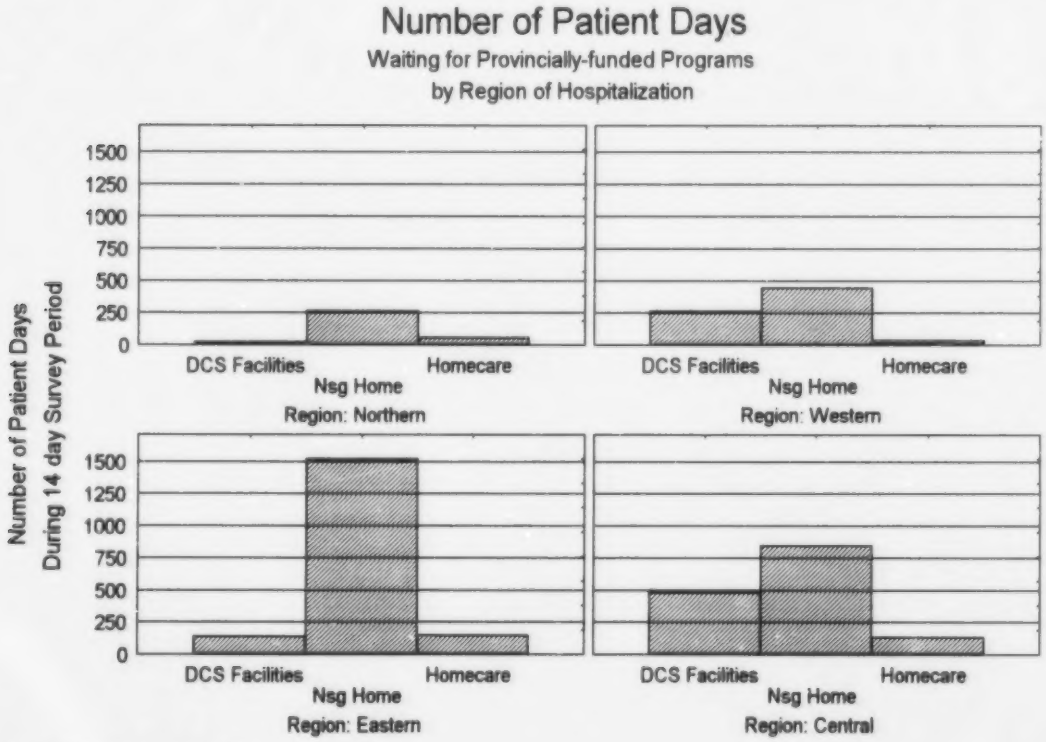
The majority of "non-acute days" were attributable to patients awaiting access to **provincially funded programs** such as Long Term Care, Home Care, Department of Community Services programs *(Annex #3, Figure 3.4)*.

Data also showed the presence of a number of patients in each region occupying hospital beds while awaiting **transfer before treatment**. However, Central Region had a larger portion of patients **awaiting transfer following treatment**.

The distribution of patients in the **"private arrangements"** category varied among regions. In Northern and Western Regions, for example, there were no patients awaiting special housing. However, whether this indicated an absence of supply or demand is not known.

The category **"patients with problems"** identified individuals who were either chronically hospitalized because of their health problems or proved to be a challenge to place in the community.

In Central Region, for example, this category contained a large portion of persons with mental health problems, probably reflecting the presence of a tertiary psychiatric facility.



(Annex #3, Figure 3.4)

This problem has received considerable attention over the past few years. In 1998, a patient Fatality Inquiry made specific reference and recommendation:

> *" the failure to provide (this patient) with a long term small option placement deprived him of an opportunity to regulate his diet, medication and possibly his behaviour... it is recommended the Minister of Community Services provide an appropriate facility or facilities, which would address the need, especially in the young. To do less is to criminalize mental illness and the mentally ill."*

In 1998-99, the Psychiatric Facilities Review Board annual report states:

> *"On numerous occasions the Board has been confronted with situations wherein, on the evidence of the treating psychiatrist, the patient is being held in a psychiatric facility because adequate provision for support in the community does not exist... absence of supervision of medication, and an appropriate small options home or other supervised situation is not available."*

Qualitative Comments

455 of the returns provided written comments in addition to the quantitative information. 50% (230 entries) of these were related to **Long Term Care**, 28% (26 entries) were related to **home discharge** and/or to **Home Care services**, and 22% (99 entries) were related to delays in **transfer** to other facilities.

Long Term Care

Of the 230 comments on Long Term Care, 120 related mainly to problems with placement resulting from process barriers and/or family-related issues. Regardless of whether or not a bed was available, placement could not occur if there were process delays such as:

- arranging classification meetings with Department of Community Services for mental health patients
- delays in Department of Veterans' Affairs (DVA) arrangements
- delays in completing financial papers

In other instances, patients had been admitted to hospital in an effort to speed up the process started when the patient was in the community. Also, Nursing Homes were felt to be unwilling to absorb the costs of dressing trays, tube feeds or special mattresses. Many of the comments (40%) related to delays associated with financial arrangements. In any dispute regarding finances, the patients remained in the acute care bed until resolution, whether this took weeks or months. Patients and families may also have refused to accept placements, for a variety of reasons. Hospital staff were often not kept informed of the status of the classification.

66 entries noted that patients remained in acute care beds as the level of care they required

was very high and could not have been provided in Nursing Homes or any other community setting at that time.

44 entries in this category identified the need for care facilities other than nursing homes such as Group Homes, Small Options and community care for mental health patients.

Care at Home

The second largest group of comments,(126) related to home discharge and/or need for more services at home. 53 comments spoke about delays in patients returning to their home for reasons such as the home requiring modifications; special equipment required; arrangements for private caregivers; patient or family refusal to leave hospital; caregiver had become ill; not able to afford required medication.

32 entries were related to Home Care. These remarks mostly concerned the need for higher HC limits exceeding the service limits now offered by Home Care Nova Scotia. Some of the examples given were for treatment of patients with simple pneumonia, IV heparin, IV antibiotics, dressings for ulcers, the need for palliative and respite care.

Transfer Issues

99 entries related to transfers between facilities. The most frequent delays cited in this category were due to "no bed available," "wait for Cardiac Services" and "wait for rehabilitation admission."

3. Review of Nursing Home Sector

Approach

The Review Team recognized that, like hospital patients, a number of Nursing Home residents may have been more appropriately served in an alternative setting. The Team, therefore, formed a Subgroup to identify key factors that may impact the appropriateness of Nursing Home placements and to recommend courses of action to address these factors.

The Subgroup included Long Term Care program staff from the Department of Health and two Nursing Home administrators appointed by the Nova Scotia Association of Health Organizations and the Continuing Care Association of Nova Scotia. Over a two-month period, the Subgroup examined existing sources of Nursing Home data, conducted a literature review, and reviewed Nova Scotia's overall system of Nursing Home services.

Scope of Review

The Subgroup's ability to capture the necessary standardized resident-level data was severely constrained. Annual nursing home licensing reports, the best source of available quantitative data,

was insufficient to determine the number of Nursing Home residents who may have been more appropriately served in an alternative setting. The available data yielded little more than a general picture of Nursing Home residents and Nursing Home utilization.

Although the Subgroup was unable to quantify the extent of inappropriate Nursing Home bed utilization, it was, through a qualitative analysis, able to identify three major systemic characteristics that may impede the cost-effective use of Nursing Home beds. In particular, the Subgroup has reviewed the way Nursing Home beds are accessed, the funding of Nursing Homes, and the planning/availability of an appropriate mix of a broader range of "continuing care" services, including Nursing Homes.

Findings

The Subgroup's paper entitled "A Review of the Utilization of Nursing Home Beds" *(Annex #4)* outlines a number of statistical findings related to Nursing Home residents and Nursing Home utilization. Some of the more salient points are listed below:

- Ratios that describe beds per population 75 years or older indicate that the availability of Nursing Home beds varies by county. However, other factors must be taken into account before determining whether a particular county is over- or under-served, e.g. migration patterns, and the availability of other continuing care services such as Residential Care Facilities, etc..

- Occupancy rates indicate that Nursing Home beds are highly utilized with few vacant bed days. The average annual occupancy rate for Nursing Homes is over 99%.

- Turnover rates of Nursing Home beds indicate that the care needs of residents vary from facility to facility. While the average turnover rate for the province is about 32%, some facilities post rates of under 20% and others exceed 50%.

- Twenty of the seventy licensed Nursing Homes permit private pay applicants to be admitted without a provincial "classification" for care eligibility. One fifth of Nursing Home residents are private pay.

- The vast majority of Nursing Home residents require nursing care and or nursing supervision. For instance, 84% of Nursing Home residents are classified as requiring Type 2 "nursing care."

The findings from the qualitative review and analysis are described in summary form under three major systemic features:

1. <u>Access</u>

   Despite a limited pool of licensed Nursing Home beds in the Province, admission to beds is

not guaranteed to be based on need alone. Access can vary depending on the individual's ability to pay. Furthermore, an exploration of the most appropriate care alternatives is not assured prior to making a Nursing Home placement.

2. Funding

The system of funding Nursing Homes, involving a flat per diem rate, does not adequately recognize the variable care requirements of residents. A disincentive exists for Nursing Homes to accept applicants with higher care needs.

3. Service Availability/Planning

Under the government's current accountability framework, planning for continuing care services has tended to be fragmented and conducted more on a program by program basis. In the absence of a system-wide approach to planning the broad array of continuing care services, achieving the right mix of service options is jeopardized. In fact, a Canada-wide review of continuing care programs illustrates several continuing care services that are not available or only partially developed in Nova Scotia.

The Subgroup also recognized that several initiatives are underway to ameliorate each of these three systemic deficiencies.

First, the government has announced its commitment to a single entry system. The single entry model, as it has been developed in most other provinces, includes a single entry access mechanism, coordinated assessment and placement, and coordinated case management. Under this system of access, only those applicants who have a demonstrated need will be considered for Nursing Home placement.

Second, the Department of Health has announced a Demonstration Project to test the Resident Assessment Instrument and its associated case mix classification system called the Resource Utilization Grouping (RUG) system. The RUG system produces valid and reliable case mix data that is needed to develop a funding system that allows for the equitable distribution of resources based on a recognition of the variable care needs of nursing home residents.

Third, as part of the government's commitment to work toward the full integration of the Departments of Health and Community Services as it relates to continuing care, the Departments are engaged in discussions regarding program responsibilities and accountabilities. Also, the Department of Health is reorganizing itself to support a better integration of continuing care programs. These initiatives are an indication that the government is moving toward an accountability framework that will maximize the probability that planning and resource allocation for continuing care will be conducted on a system wide basis. Such an approach to planning is critical to determining the appropriate mix and levels of institutional, home and community based programs.

4. Key Issues &Recommendations

This review of health facilities was limited in both its scope and its application. It did not address all the reasons which may have contributed to patients occupying acute care beds when they could more appropriately have been cared for in another setting. The study focused solely on the apparent barriers preventing patients from being discharged in an efficient and timely fashion from the hospital. The study did not address issues around inappropriate admission or the potential for process improvements in in-patient care.

The team was also conscious of the significant limitations of the survey tool. Many of the participants in the study were not familiar with utilization review methods and tools. The results of this survey would therefore have been affected by a "learning curve" on the part of those undertaking the review. The tool itself was simply a questionnaire to permit an "environmental scan" rather than a rigorous utilization review. Furthermore, any information gleaned from the short, two-week time-frame in each facility was obviously specific only to that period of time. Any results cannot, and should not, be generalized as representative of any other point in time. The survey allowed only a minimum reflection of some of the issues.

Despite these limitations, some important information emerged from the review. Based on available information, a high proportion of acute hospital bed days are used by individuals who do not strictly require an acute level of care. This supports the views frequently expressed by many professionals in the hospital sector. Some of these bed days may potentially be amenable to process improvements or more efficient throughput but much of it reflects a lack of alternative care locations. There are either no nursing home beds available for many patients or their care needs are too heavy and complex to be accommodated within current long term care resources.

The review of the Nursing Home sector demonstrated that there was in fact very little flexibility within that sector of care. Occupancy rates in Nursing Homes are consistently high, there is a high demand for beds and residents' care needs have stretched the capacity of the LTC sector almost beyond the limits of available staff and resources. The combined effect has been a "gridlock" between the acute and long term care sectors.

A number of hospitals — most notably the QEII — have responded to patients' needs by establishing a "Transitional Care" type of unit. While this may have helped to address immediate needs, it has posed a number of policy dilemmas. What are the established clinical criteria for "entry" to and "exit" from a transitional unit of this type? Does the fact that this type of care exists in one region challenge accessibility and equity provisions in the rest of the acute care system? Should this in fact be an insured service or should patients be charged — either wholly or partially — for their care on this type of unit?

Superficially, it might appear that the problem lies in insufficient Nursing Home beds. This answer is simplistic. While the province may indeed need "more of the same" type of nursing home beds, the introduction of a single entry access system and a consistently applied eligibility policy have, in other jurisdictions, resulted in an actual reduction in need for Nursing Home beds. However, the effect of a system improvement of this type will not be realized immediately and it takes many

months for these results to emerge. It may not be the most efficient use of existing resources to embark at this time on a major expansion of Nursing Home bed capacity throughout the province. More readily apparent is the over-riding need to begin to assist patients with multi-system, heavy care requirements, exceptional care needs that cannot be met in the current system.

The Working Group offers a word of caution. The relationship between quality of care and system efficiency is a delicate balancing act. Any sudden shift or change in the way services are provided in one sector of health care may have a profound effect elsewhere in the system, either in terms of increased costs or diminished quality of patient/resident care. The end result may increase costs rather than the reverse. Also, a solution that may appear to make sense for one region or district may not, in fact, constitute the appropriate response for another area. We must respect the inherent inter-connectedness of the various sectors of the health care system. Community-specific solutions will be needed to achieve the appropriate outcomes.

Any actions taken as a result of this review must not be seen as the definitive answers. As with any planning exercise, there is a need to be ever-vigilant and pro-active to ensure that the system remains up-to-date and responsive to current issues. The Clinical Services Review initiative may be the catalyst to achieve this ideal.

Recommendations

In compiling the following recommendations, the Facilities Review Committee altered some of the wording contained in the original documents constituting the Annexes to this report. This was done in an effort to integrate the recommendations and to ensure a more logical sequencing of ideas. We trust, however, that we have preserved the full intent of the analyses.

With these thoughts in mind, the Facilities Review Committee offers the following recommendations:

1. There is a wide variation in the utilization activities and measures used in hospitals in Nova Scotia, ranging from ongoing use of a recognized utilization tool to no measurement. The province cannot make direct comparisons of performance due to the absence of uniform and complete information.

   Recommendation #1

   The Department of Health should establish a province-wide approach to utilization measurement, using recognized, validated tool(s) to allow comparison of practices across hospitals in Nova Scotia.

2. The consistency of reporting by hospitals to the Department of Health varies markedly throughout the province. Currently, there are no data on expenditures; no measures to determine efficiency in areas such as workload measurement, productivity, cost per service; no standing provincial requirements for reporting, with the exception of the Discharge Abstract Database.

Recommendation #2

The Department of Health should establish a comprehensive, province-wide system(s) of information to support meaningful, accurate reporting on performance.

3. Hospitals experience delays in transferring patients both prior to interventions and following interventions. There do not seem to be effective mechanisms/processes that would allow more efficient transfer.

Recommendation #3

The Department of Health should establish a working group to identify the underlying cause of transfer delays to ensure a more efficient transfer of patients between facilities for acute care testing and interventions. (Note: details on reasons for patient transfers between hospitals and nursing homes would also be useful information for planning purposes.)

4. Many patients, especially Mental Health patients, remain in acute care beds because there are no facilities in the community to meet their needs. These patients do not require the services provided by current Nursing Homes, but do have specialized needs. This problem has drawn considerable attention over the past few years.

Recommendation #4

The Department of Health should enter into discussions with the Department of Community Services to address this issue.

5. The process for determining eligibility and admission to Nursing Homes is complicated and lengthy. Process issues accounted for many delays. The Department of Health has long been aware of these difficulties and is in the process of developing a plan for a single entry system of access that will streamline intake, assessment, placement, and case management functions, based on priority of identified needs

Recommendation #5

The Department of Health should continue with the current plan to implement the single-entry system of assessment, placement and case management, as a priority issue. The Community Care Branch of the Department of Health should establish a working group to address the process issues and streamline the eligibility and admission process. Again, it is essential that the acute care sector is a meaningful partner in this planning process.

6. The system of funding Nursing Homes does not adequately recognize the variable care requirements of residents. A disincentive exists for Nursing Homes to accept applicants with higher care needs. The Resource Utilization Grouping (RUG-III) System represents the leading edge in case mix classification systems for long term care facilities.

Recommendation #6

The Department of Health (Community Care Branch) should (a) ensure that the demonstration project for the Resident Assessment Instrument and its associated case mix classification system (called the Resource Utilization Grouping System) proceeds as planned and (b) begin the development of a Nursing Home finance system capable of utilizing the Resource Utilization Grouping system's case mix classification data.

7. The current system does not provide care for patients with exceptional, specialized, chronic care or clients with high care needs. As a result, many of these patients remain in acute care beds for an indefinite length of time as their needs exceed the services offered in current Level 2 facilities.

Recommendation #7

The Department of Health should establish specially designated "Heavy Care" beds in the province and should convene a working group to look at the location of beds, staffing requirements, access and related policy issues. As the Single Entry Access and the Resource Utilization Grouping system approaches proceed, the Department should ensure that the Acute Care and Community Care sectors collaborate closely to ensure that the care needs of this population are appropriately addressed.

8. In Nova Scotia, the Departments of Health and Community Services are accountable for the majority of publicly funded continuing care services. There is no structured, integrating mechanism between the Departments to plan and manage these services.

Recommendation #8

The Departments of Health and Community Services should ensure the integration of the their two Departments, as they relate to Continuing Care. The first step in this process may be achieved through the development of an agenda of specific integration issues.

9. Single Entry Access (SEA) will provide client information useful for planning continuing care services. There is an international trend toward a declining focus on building institutions and an increasing focus on supporting people in their own homes until this approach becomes cost-ineffective. Community based alternatives remain underdeveloped in Nova Scotia. Caution should be taken when planning the expansion of continuing care services such as Nursing Homes, as the increasing pressures do not necessarily always translate into a need for more Nursing Home beds.

Recommendation #9

(a) The province of Nova Scotia should invest in community-based continuing care services such as adult day, respite, community occupational therapy and

physiotherapy services, and explore different models of facility-based care. Input from communities regarding their needs and capacity is essential.

(b) Planning for all these program components should be done within the context of, and in relation to, all continuing care components and developments in other program areas such as palliative care and geriatric assessment programs.

(c) New nursing home beds should only be considered within the context of the outcomes accruing from other system refinements such as Single Entry Access, enhanced home care services.

(d) The Department of Health should develop "Bed Planning Guidelines" for the allocation of any new licensed nursing home beds. The work of the (now disbanded) Long Term Care Working Group's Subgroup on Bed Planning Guidelines should be incorporated into the guidelines.

10. Implementation of a single entry system will take time and immediate action is required to alleviate some of the problems.

Recommendation #10

The Department of Health should introduce a policy requiring all Nursing Home applicants, regardless of their ability to pay, to be screened using the same method to ensure their care needs are consistent with the services offered by Nursing Homes. Concurrent with the introduction of this policy, the Department of Health should collaborate with the Nursing Home sector to develop a province-wide wait list management policy and information system.

Additional Issues

The preceding recommendations reflect some of the actions that are needed to address the issues arising from the findings of the Review. However, other comments and issues came to light which, although not addressed by the review process, nonetheless require attention. These issues include:

- A number of hospitals in Nova Scotia have established "Transitional Care" or "Sub-acute Care" units, based on entry and access criteria specific to the hospital. The result has been inequities in the provision of "insured " services throughout the province.

  The Nova Scotia Department of Health should immediately establish a clinical program planning working group, with representation from the medical community, to develop clear clinical guidelines on entry and access criteria to "sub-acute" and "transitional care" services. This group should also recommend the policies, terms and conditions which should prevail, making specific reference to the insurability (or otherwise) provisions for these services.

- A number of the delays in discharges to home may potentially be avoided by careful, advance, preplanning through early referral. Examples of this would be when ensuring modifications to the home, scheduling of family vacations and arrangements for homecare services.

- There is no process in place to address funding for the special equipment, drugs and supplies the patient may require for discharge. The Departments of Health and Community Services have a shared responsibility to address these funding issues which can often result in delays in discharge of patients.

In closing, the Facilities Review Committee recognizes the pressing need for action to address many of the issues highlighted by this review. While we do not necessarily recommend "new" nursing home beds, we recognize that the health system faces immediate challenges in meeting the care needs of many individuals currently awaiting alternative levels of care provision. We suggest that the Provincial Homecare Program is well placed to offer a flexible, cost-effective, interim option for mobilizing some of the resources needed for this particular population. That approach, together with the judicious use of existing hospital bed "stock," may provide the province of Nova Scotia with a viable and immediate answer to the serious challenges that we face today.

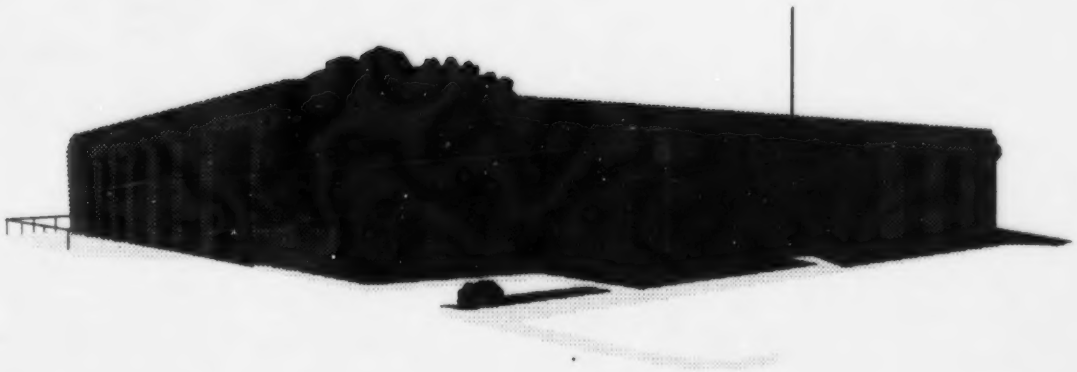
Annex #1

Transitions in Care
Phase I Report

Transitions in Care

N.S. Department of Health
Facilities Review

Phase I Report



Work in Progress

November 9, 1999 - December 6, 1999

EXECUTIVE SUMMARY

The Nova Scotia Government promised, upon assuming office, that it would "*In partnership with health care providers, immediately undertake a comprehensive assessment of all health care facilities in order to ensure that Nova Scotians are receiving the right type of care in the appropriate facility. This review will be completed within 90 days of forming government.*"

Medical advances, shifting demographics, altered public expectations and financial pressures have place an enormous burden on health systems — particularly in the hospital sector. In Nova Scotia, the number of hospital beds declined from 5,149 to 3,135 between 1991/1992 and 1999/2000. Because hospital beds are, and will continue to be, a scarce and expensive resource, they must be used as efficiently as possible.

For their initial assessment, the Nova Scotia Department of Health's project team drew on both qualitative and quantitative information. During consultations with medical staff across the province, two (2) departmental medical consultants were advised that there was likely, at any given time, to be a surprisingly high percentage of patients in hospital beds who did not strictly need the services of an acute care facility. At the same time, the review team studied existing reports from across the province. Not all hospitals in the province analyzed the appropriateness of the use of their beds nor was there sufficiently uniform and complete information to allow analysis and comparisons between hospitals.

The review team, therefore, developed a unique survey instrument for use in every hospital in the province. Based on limited but reliable data, the team identified that a high percentage of likely "non–acute patient days" could be attributed to three (3) principle system problems, namely:

- wait for assessment or placement in a Long Term Care facility
- wait for assessment or discharge into Home Care services
- patients' care needs exceeded the level of service usually provided by a Long Term Care facility.

Working within pre–existing patient care commitments, such as accreditation surveys or patient transfers, all hospitals in Nova Scotia will provide a "snapshot" of the various obstacles they encounter between these levels of care. The two–week long survey is scheduled to take place between November 8, 1999 and December 5, 1999, over a 14–day time period of the hospital's choice. The review and analysis of this data, which will take place during December 1999 and the early part of 2000, will provide a more complete picture of the scope, magnitude and reasons for delays in appropriately meeting patients' care needs in Nova Scotia.

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TRANSITIONS IN CARE

N.S.D.O.H. Facilities Review — Phase I Report

1. INTRODUCTION

Upon assuming office, the Nova Scotia government stated that the province would:

> *"In Partnership with health care providers, immediately undertake a comprehensive assessment of all health care facilities in order to ensure that Nova Scotians are receiving the right type of care in the appropriate facility. This review will be completed within 90 days of forming government. Implementation of recommended changes will begin immediately so that patient needs are properly met while providing more cost–effective service delivery."*

The underlying intent of this initiative was to develop a more cost–effective system of service delivery to ensure that Nova Scotians would receive the necessary care in the most appropriate setting and in a timely manner.

2. BACKGROUND TO THE STUDY

Medical advances, shifting demographics, altered public expectations and financial pressures have placed an enormous burden on health systems, both in providing services differently and doing so within available funds. These changes have had a profound impact on the province's Acute Care and Long Term Care facilities.

2.1 Hospital/Acute Care

Nova Scotia provides hospital care to all residents of Nova Scotia, as well as to certain residents of New Brunswick, Prince Edward Island and Newfoundland. There are 37 acute care facilities with 3,135 in–patient beds in Nova Scotia (1999/00). All eligible residents of the province are entitled to receive insured hospital services. *"Insured Services"* refers to both in-patient and out–patient services.

Hospital care (also referred to as *"Acute"* care) is generally episodic and short term in nature, encompassing prevention, diagnostic, emergency, treatment, rehabilitative and palliative services. Broad clinical program areas include obstetrics/gynecology, pediatrics, medical and surgical services, intensive care and diagnostic services, as well as other specialty services. Within each of these diagnostic, treatment and rehabilitative categories lies a wide range of sub–specialty programs and services.

The various levels of acute/hospital care are termed **primary, secondary or tertiary care. Primary acute care** is delivered by the health care professional first contacted by the patient. The types of primary services include low risk obstetrics, pediatrics, geriatrics, mental health, emergency, medical surgical, rehabilitative and palliative care, provided by the most appropriate, qualified health care provider. General practitioners also provide primary care services within community hospitals and may assist in some surgical procedures.

Secondary acute care services include more complex diagnostic and treatment services provided by physicians and health care professionals with specialized training. Diagnostic and treatment services are provided on referral form primary care service levels. A number of general practitioners also provide this level of service. Secondary care can be available to individuals either within their region or another region.

Tertiary acute care refers to sophisticated diagnostic and treatment services which are provided on referral from physicians and other health care professionals. Tertiary care is provided to patients with overwhelming severe illness and/or complications and:

- Should be accessible to all residents with complex needs or medical conditions.
- Require a large population base to maintain professional expertise and competence, as well as cost–effectiveness of service provision.
- Require sufficient, highly specialized physicians and health care providers to support them.

- Entail extensive interdisciplinary teamwork.
- Require sophisticated facilities and equipment.

Examples of tertiary care services would include open heart surgery, radiotherapy, neuroscience, neonatal and pediatric intensive care, high–risk antepartum and intrapartum obstetrics, etc. Nova Scotia provides a number of tertiary level services to residents of Prince Edward Island, New Brunswick and Newfoundland. Other highly specialized tertiary care services may be provided to Nova Scotians in another province through inter–provincial arrangements. Examples of these would be pediatric bone marrow transplants, lung transplants, specialized and highly sophisticated diagnostic or treatment procedures and equipment.

Between 1991/1992 and 1999/2000, the number of hospital beds in Nova Scotia was reduced from 5,149 to 3,135 (a 37% reduction). This was carried out as a deliberate strategy, in response both to statistics showing that Nova Scotia had one of the highest national rates of bed use per 1,000 population and to evidence of relatively low occupancy rates. However, over the same period, the provision of acute care services on an ambulatory (out–patient) basis has increased significantly.

Because hospital beds are a very expensive resource, health care administrators and professionals must make sure that they are used as efficiently as possible, so that they benefit all those who need this level of care. The hospital sector, therefore, depends heavily on strong linkages with the Long Term Care (Nursing Homes, Homes for the Aged) and the Home Care sectors, for hospital patients who require these services when they leave hospital.

2.2 Long Term Care

The Department of Health is responsible for all Nursing Homes and Homes for the Aged which provide facility–based Level 1 (personal care and/or supervision) and Level 2 (nursing and/or supervision) care. The program meets both social and health needs. Although residents in Long Term Care facilities are primarily seniors with an average age in the mid-80s, there are younger adults and some children in Homes.

There are 70 Nursing Homes and Homes for the Aged in Nova Scotia, of which 22 are municipally owned, 20 are private for profit, seven (7) are based in hospitals and the remainder (21) are non–profit and charitable organizations. There are a total of 5,856 licensed beds in Nursing Homes and Homes for the Aged, with an overall bed occupancy rate of more than 98%.

Access to these beds is determined through a process of intake, assessment, classification and placement. Long Term Care is not an insured service. Residents who are financially able to pay the "per diem" charges, do so. The Department of Health provides a financial subsidy to residents who require this assistance (roughly 75% of residents).

2.3 Home Care

The province provides home care services to residents of Nova Scotia through "Home Care Nova Scotia (HCNS)." This program "coordinates the delivery of an array of services to assist Nova Scotians of all ages to achieve and maintain their maximum independence while living in their own homes and communities." Persons applying for admission to HCNS undergo a generalist assessment process which gives a complete profile of the individual's clinical condition and circumstances. This multi–disciplinary assessment determines the unmet functional needs which can be met safely and effectively by home care services.

The core services of Home Care Nova Scotia include :

- Home support, such as help with general cleaning, laundry and meal preparation.
- Personal care such as assistance with bathing, dressing and toileting.
- Nursing services such as dressing changes, IV therapy and general nursing care.
- Home oxygen services which provide funding for an oxygen concentrator and related supplies.
- Family relief/respite services in the home.
- Referral and linkage to physicians and other community based services as appropriate.

These services are administered and delivered by the Department of Health through regional home care offices in the province's four (4) current health regions. The program's Care Coordinators, who perform assessment and case management functions, are located in communities throughout the province and in all hospitals in Nova Scotia.

HCNS services are delivered by a network of health care professionals, home support workers and physicians working together with the individual and family. There are no fees for nursing services provided through Home Care Nova Scotia. Based on the recipient's income and ability to pay, there may be a minimal fee for home support, personal care or home oxygen services.

3. THE REVIEW

In response to the government's commitment, the Nova Scotia Department of Health assembled a project team to undertake a comprehensive assessment of the use of health care facilities (*Appendix #1*). The team's logical first step was to review existing reports from the hospitals and Regional Health Boards, in an attempt to:

- Identify whether hospital beds were being used appropriately and efficiently.
- Describe the scope and magnitude of any problems/barriers resulting in delaying patients from receiving appropriate care.

The Project team initially drew on both qualitative and quantitative information. This first **"diagnostic" phase** consisted of two (2) parallel initiatives. Two (2) consultant physicians from the Department of Health had planned a consultation process with hospital chiefs and presidents of medical staff across the province. This consultation process had two (2) primary objectives. First, it was intended to provide an avenue for medical practitioners to make their opinions known on key issues facing the health care system, with particular reference to hospitals. Second, physicians were informed of the planned survey and were invited to give their qualitative, written perceptions of current practices around acute care bed utilization.

Concurrent with this exercise, the Department of Health review team examined quantitative information available through existing reports.

3.1 Physicians' comments

The Department of Health medical consultants visited all but two (2) of the hospitals in Nova Scotia. Based on the feedback they received from their colleagues across the province, the consultants made a number of observations. Medical staff generally had great confidence in, and respect for, the nursing and social service staff who carry out the utilization management functions in the hospitals. However, few physicians and site managers in the regions had heard about the planned review of facilities in the province, despite an earlier, parallel contact with Chief Executive Officers on the subject.

The medical staff estimated that, in general, there were likely to be between 20 - 60% of patients in acute care beds who did not need to be in an acute care facility. The most common reasons for this were felt to be the non–availability of nursing home beds, or Level 3–type care, but the absence of operational efficiencies was felt to contribute to the problem. There was also a perception, particularly outside the Metro region, that home care had provided an additional, new service rather than offering alternatives to in–patient delivery of acute care. Internal to the hospitals, physicians experienced a number of delays in scheduling and receiving reports on tests and procedures, resulting in increased lengths of stay for their patients. There were also difficulties in transferring patients from regional hospitals into Halifax, particularly for intensive care and cardiac care.

3.2 Review of reports

As the consultations with physicians were taking place across the province, the Review team studied existing reports from the facilities and regions. The documents included a broad range of indicators, such as percentage occupancy, average length of stay, waiting times for referral to specialized programs, same day admission surgery rates, alternate level of care days and "may not require hospitalization days", separations and days, etc.

However, there was little consistency in the method of reporting and the range of

indicators used. Efficiency measures and changes in volumes were reported more frequently than were indicators of outcome, appropriateness or effectiveness. For example, although studies of the appropriateness of hospital use can demonstrate the potential for employing alternative forms of care, extensions to the basic tools are needed to identify the particular alternatives that would be appropriate. Also, attempts to monitor the appropriateness of bed utilization (i.e., by waiting times for transfers between units or transfers to specialized/tertiary service) were neither complete nor generalizable.

The level of information available through the Department of Health itself proved to be inadequate for the specific purpose of this review. These reports comprised of an Annual Statistical Report (compiled by staff of Health Information and Evaluation) and the production of a limited number of efficiency indicators, derived from CIHI data. However, since 1995/96, the Department of Health's capacity to produce meaningful administrative reports had been reduced. The elimination of the former provincial Management Information System (MIS) meant that there were currently no provincial indicators on workload or cost per unit service.

In recent months, the Department of Health had established a Working Group on Performance Indicators, with membership from the regions, NDOs and the Department of Health. Their April 1999 report showed rates for a variety of health indicators, including four (4) hospital–based indicators — rates for Caesarean section, same day admission, re–admission and day surgery.

The review team recognized that, in general, any existing reports were of greater value to the individual facility than they were to an analysis of the system as a whole. The preliminary review of "state–of–the–art" hospital use of tools indicated that there was a wide variation in the use of the tools and that the type of utilization activities ranged from on–going use of a recognized utilization tool to nothing. The review team concluded, based on their analysis of existing information, that direct comparisons across the province could not be made, due to the absence of uniform and complete information.

4. NEXT STEPS

The review team's task, therefore, was to develop a standard approach to collecting the information necessary for making fully informed decisions. Despite the limitations of the existing reports, the team concluded that hospitals were very likely to be providing a substantial amount of "non–acute" care.

This assumption was supported by a number of sources including preliminary feedback from the physicians' consultation process, data from Cape Breton Healthcare Complex and an earlier study at QEII Health Sciences Centre. Information provided by the Cape Breton Healthcare Complex identified that 60% of the use of that facility's "non-acute patient days" could be attributed to three (3) principal reasons *(Appendix #2)*. The reasons were :

- Individuals waiting to be assessed for, or placed in, a Long Term Care facility.

- Patients waiting for assessment, or discharge, into Home care services.
- Patients not requiring the level of care provided by a hospital but whose care needs exceeded the level of service usually provided by a Long Term Care facility.

The remaining "non–acute" patient days were attributable to a wide variety of reasons, and were being appropriately addressed by process improvements within the Complex.

The QEII Health Sciences Centre had experienced similar results during its "Day in the Life" utilization review in April 1997 *(Appendix 3)*. This study showed that 29% of patients in the QEII did not need to be in that particular setting of care. Over half of the potentially avoidable days at QEII were related to problems with access to external resources. These patients were:

- Awaiting assessment/placement for Long Term Care (15%).
- Could be at home if services were available (20%).
- Could return to their "home hospital" (15%).

The review team, therefore, focused their efforts on the three (3) major problem areas known to delay patients' timely and appropriate access to alternate levels of care following a hospital stay. In close consultation with many service providers in the "field," the Department of Health review team developed their own survey instrument to be applied to all hospitals in the province *(Appendix #4)*. With the active support and involvement of many service providers across the province, the review team:

- Consulted widely on the proposed methodology,
- Developed a draft tool, with additional help from staff at Dartmouth General Hospital, Northern regional Health Board and QEII HSC.
- Pilot–tested the instrument in Cape Breton Healthcare Complex.
- Evaluated and adapted the tool accordingly.
- Developed an action plan for applying the survey across all hospitals in the province.

The survey phase was designed to accommodate two pre–existing but non–negotiable commitments. **First**, two (2) health regions and several hospital were scheduled to undergo accreditation by the Canadian Council on Health Services Accreditation during October and November 1999. The accreditation processes, which are highly stressful and staffing intensive, were the culmination of a costly, year–long process. They could not be rescheduled.

Second, the QEII was scheduled to move an estimated 30% of its patient population as part of a long–planned reorganization of clinical services during the same period, including general medicine, orthopaedics and transitional care, where the bulk of patients waiting for placement outside acute care is typically found. The timing for the study was therefore based on honoring the hospitals' pre–existing commitments to essential patient care activities. The study was planned to allow all hospitals to select the two–week review

period of their choice, preventing any conflict with prior clinical commitments. (The Timetable for the Review is provided in *Appendix #5.*)

At the time of writing this report, the review team is well into the second phase of the study and is being supported in this process by Dr. B. Carr and Ms Peggy Gorman (QEII HSC). **Phase 2** consists of a data gathering review in all hospitals across the province and will take place between November 8, 1999 and December 5, 1999. Each hospital will provide a two–week survey "snapshot," identifying the various obstacles to transitions between the different levels of care that currently exist.

Concurrent with the review of acute care beds across the province, staff in the Long Term Care section of the Department of Health are carefully analyzing all relevant reports and documentation within their jurisdiction. Their intention is to determine the current appropriateness of resident placement in Nursing Homes and Homes for Special Care.

5. PRELIMINARY FINDINGS

Although no conclusions can, or should, be drawn until the full survey is completed, a number of preliminary observations can be made:

- The consistency of reporting varies markedly throughout the province.
- Currently, the healthcare system has no measure of determining efficiency in areas such as workload measurement, productivity measures and cost per service.
- There are no data on expenditures.
- With the exception of the Discharge Abstract Database, there are no standing provincial requirements for reporting.

Although the actual review period is scheduled to end on December 6, 1999, the review and analysis of the data will take place early in the New Year. The review team will then have a more complete picture of the scope, magnitude and reasons for delays in appropriately meeting patients' care needs following a hospital stay.

Appendix 1

Review Team

Transitions in Care

N.S.D.O.H. Facilities Review

Review Team

DOH - Review Team (Acute Care)
Ms. Elizabeth Barker
Dr. David Elliott
Ms. Barbara Harview
Ms. Pauline MacDonald

DOH - Physician Advisors
Dr. Ross Langley (Co-Chair)
Dr. Murray Nixon

DOH - Advisory Team
Ms. Brenda Ryan
Ms. Sandra Cook
Mr. David Chadwick
Mr. Wade Were
Mr. Robert St. Laurent (Co-Chair)
Dr. John Campbell
Mr. David MacIver
Ms. Florence Hersey

DOH Technical Support
Ms. Debbie Carew
Ms. Maureen Aucoin

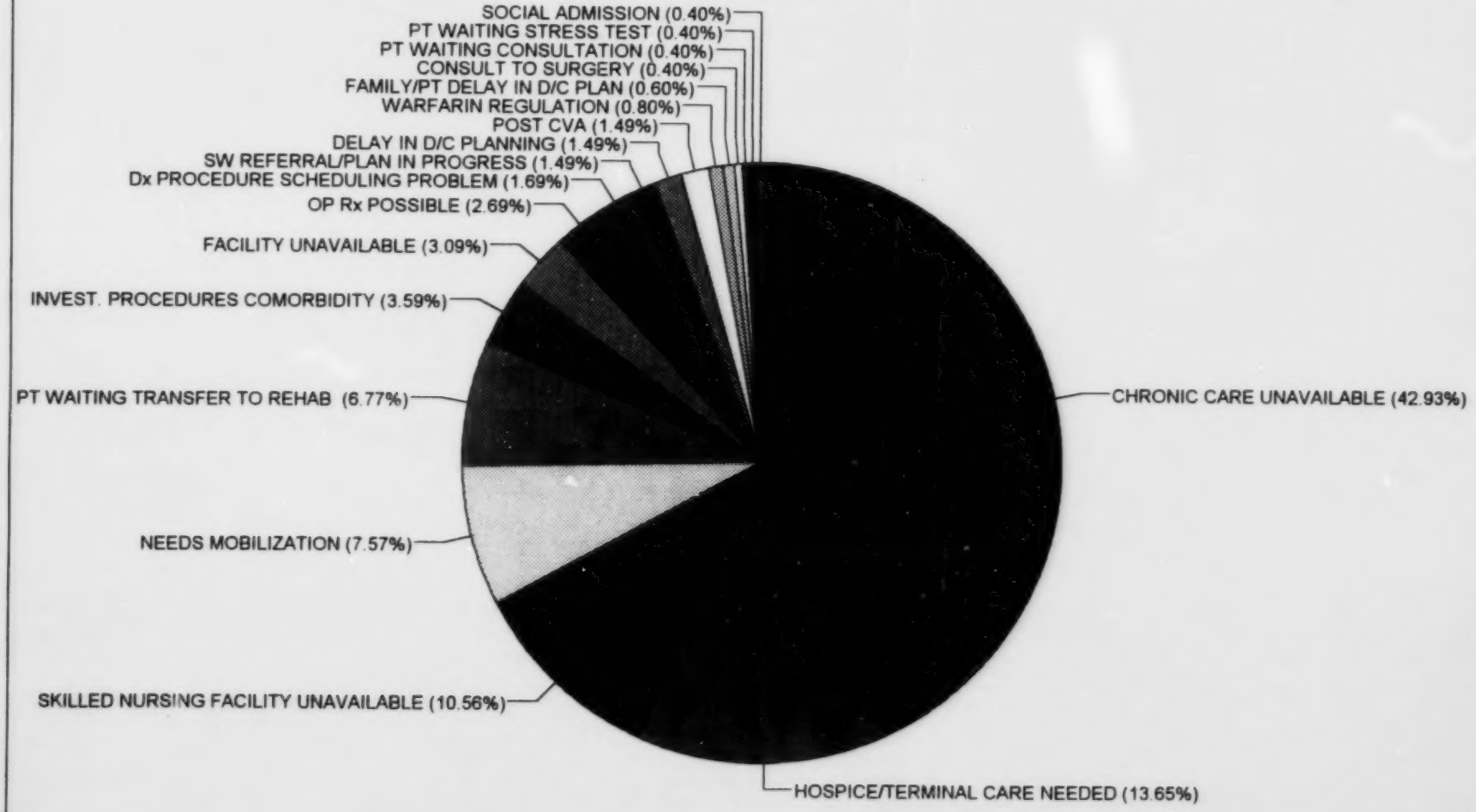
External Advisors
Ms. Peggy Gorman (QEII)
Dr. Brendan Carr (QEII0
Mr. John Malcolm (CBHC)

Appendix 2

Cape Breton Healthcare Complex

REASONS FOR NON ACUTE DAYS

CBRH AUGUST 1999 TOTAL DAYS = 1012

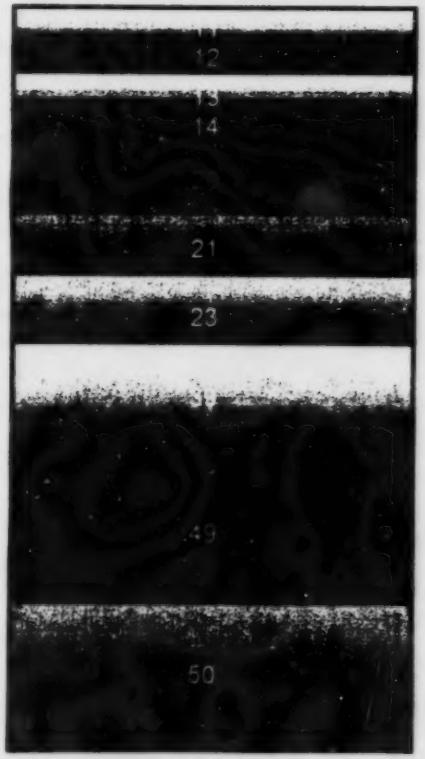


Appendix 3

QEII Alternative Levels of Care (1997)

Queen Elizabeth II
Health Sciences Centre
Clinical Initiatives Group

Why Alternative Levels of Care?



N = 252

29% of patients within the QEII on April 30, 1997, did not need to be in that particular setting of care.

This information validated an earlier survey*. (January, 1997)

*Total number of patients surveyed: 868

Appendix 4

Survey Documents (Department of Health)

NS Department of Health
Facilities Review Questionnaire
— Please refer to the Guide for detailed completion instructions —

Addressograph or Label

Name_____
Unit # _____ Hosp # _____
County of Residence _____
DOB YYYY/MM/DD Sex ☐ M ☐ F
Admit YYYY/MM/DD Discharge YYYY/MM/DD
Discharged ☐ Alive ☐ Deceased

1. Is this patient being transferred/discharged to another level/location of care (after waiting >24 hours)?
OR Could or should this patient be transferred/discharged to another level/location of care?

1.A Yes

Hospital Transfer
☐ For Tx/Dx ☐ Post Tx/Dx

Provincial Government Program
☐ NH ☐ Other LTC ☐ HC

Private Arrangement
☐ Self ☐ Family ☐ SH

☐ **Other**

If other, specify

1.B Yes, but
☐ Physical Problems ☐ Mental Health Problems
☐ non NS resident ☐ Other

1.C Additional resources required for discharge :
Check all that apply
Circle most important one

☐ Higher HC limits ☐ Supervision ☐ GP Post-D\C
☐ Meds/Supplies ☐ Palliative HC ☐ Hospice
☐ Respiratory Therapy ☐ Physio/OT ☐ Social supports
☐ Mental Health Services ☐ Other

— Complete # 2.A then STOP —

2.A Actual/est. date patient was ready YYYY/MM/DD — If other, specify

2.B Formal process begun (notice to assessor)
Yes ☐ Date YYYY/MM/DD ☐ N/A
No ☐ Patient refusal ☐ Family refusal
☐ Attending MD ☐ Other

3. Assessment by LTC/HC/DVA/Other — If other, specify
Yes ☐ Date YYYY/MM/DD **No** ☐

4. Date and Status of Assessment / Classification / Placement

Classification
Classified Date YYYY/MM/DD

Denied for LTC/HC/Other
☐ Care req. too low
☐ Care req. too high

Placement offered
☐ Refused, by patient or family
☐ Accepted ☐ Other

If other, specify

5. Funding required for placement — If other, specify
☐ Private ☐ Provincial public funding
☐ DVA \ VAC ☐ Other

Date YYYY/MM/DD	Completed by	Phone/pager number

Office use only	Unique ID	Questionnaire ID

The Cheat Sheet

Survey forms are to be completed at the time of discharge and on the last day of the survey on all discharges who meet the inclusion criteria, PLUS, all patients still waiting in hospital who would meet the inclusion criteria if discharged. Treat deceased patients as you would a regular discharge.

Alphabetic Hospital list	Hosp #
Aberdeen Hospital	11
All Saint's Springhill Hospital	12
Annapolis Community Health Centre	13
Bayview Memorial Health Centre	58
Buchanan Memorial Hospital	15
Colchester Regional Hospital	18
Dartmouth General Hospital	65
Digby General Hospital	20
Eastern Memorial Hospital	22
Eastern Shore Memorial Hospital	23
Fishermen's Memorial Site - Health Services Ass'	24
Glace Bay - Cape Breton Health Care Complex	75
Guysborough Memorial Hospital	27
Hants Community Hospital	37
Health Services Association of the South Shore	14
Highland View Regional Hospital	30
Inverness Consolidated Hospital	34
IWK Grace Health Centre	86
Lillian Fraser Memorial Hospital	32
Musquodoboit Valley Memorial Hospital	33
New Waterford Consolidated Hospital (CBHC)	63
North Cumberland Memorial Hospital	35
Northside Harbourview Hospital (CBHC)	41
Nova Scotia Hospital	77
Queen Elizabeth II Health Science Centre	85
Queens General Hospital	38
Roseway Hospital	39
Sacred Heart Hospital	47
Soldiers' Memorial Hospital	48
South Cumberland Community Care Centre	49
St Mary's Memorial Hospital	45
St Martha's Regional Hospital	43
Strait - Richmond Hospital	68
Sutherland Harris Memorial Hospital	50
Sydney - Cape Breton Health Care Complex	73
Twin Oaks Memorial Hospital	52
Valley Regional Hospital	67
Victoria County Memorial Hospital	53
Yarmouth Regional Hospital	56

Inclusion Criteria

Is the patient making a transition to a different level or location of care (Discharge to nursing home, homecare, transfer to another hospital, *etc.*) ?

OR

Could the patient make a transition to a different level of care if certain services were available outside the acute care setting ?

AND

Has the patient been waiting for a period of greater than twenty-four hours for the required/needed care to become available ?

Questions

1. If included per the study criteria above, where would the patient go?

1.A Answer **yes** if patient has waited >24 hours, or is still waiting on the final study day. Please indicate actual or planned discharge option.

1.B Answer **"yes, but"** for chronic, long-stay patients who are unsuitable/ineligible for currently available post-discharge services.

1.C Additional resources required for discharge – You may check more than one option but please <u>circle</u> the most important factor delaying/preventing this patient's discharge from your facility.

2.A Actual/est. date patient was ready - Insert the date you know (or estimate) that the patient would have been capable of being discharged had the required resources been ready or available.

2.B Formal process begun (notice to assessor) For patients where an external process (*i.e.* classification for LTC or assessment for HomeCare) must take place, please insert the date that the initial documentation was completed and the external assessors notified.

For patients where a formal external process is not involved, please estimate the date that the patient could / should have made a transition to a different level of care. Special cases: Inter-hospital transfer – use the date a bed was requested. Chronic long stay patients – estimate the date their condition stabilized.

3. What the date the assessment was <u>started</u>, *i.e.*, forms & patient were reviewed, *etc.* Answer *no* if the assessment has not started, or if no external assessment is required.

4. If a classification has taken place, please provide the date of classification, regardless of result.

5. What funding is required for placement?

NS Department of Health
Facilities Review Questionnaire

Purpose To provide insight into the experience of facilities in terms of planning for, and arranging discharge of, persons whose health care needs are believed to be better suited for care in a different environment. This included situations where persons are awaiting transfer to other hospitals, or discharge to care in the community. The intent is to identify bottlenecks in transferring patients, to accessing existing post-discharge services, or to identify persons who cannot be discharged because of the lack of appropriate resources in the community. This first phase is concerned with the situation existing in acute care facilities. A planned second phase will focus on those services and facilities providing care post-discharge.

Authority The facilities review is being conducted under the authority of the minister of health.

Methods 1) A two-week "snapshot" of discharges of persons meeting the study inclusion criteria, plus a one day profile of persons still waiting for transfer/discharge. A short questionnaire is to be completed on a persons meeting the inclusion criteria during the two-week period.
2) Daily census information for each of the days during the study.

Confidentiality The information provided will be covered under the confidentiality provisions of the Hospitals Act and will be treated in a manner that ensures security of the information and guarantees confidentiality of the individuals concerned.

Analysis The analysis will look at the mix of patient types and transfer/discharge options in an attempt to identify areas lacking appropriate availability and/or types of discharge options. While some analysis may be done at the hospital level, of greatest interest will be comparisons done at the county/regional level and according to size/type of hospital.

Reporting The questionnaire results will be combined with other information to produce a report to cabinet.

Dissemination The report will be distributed to health boards, facilities and department of health departments responsible for programming and policy as well as to healthcare professionals.

Guide for Responses to the NS Department of Health Facilities Review Questionnaire

Introduction

This guide is designed to help explain on whom the questionnaires should be completed and what each question means. The questionnaire itself does not provide much information on the questions or responses and **must be completed using this guide as a reference.**

General

If an addressograph or label is available, please imprint or attach in the upper right corner.
Insert your hospital # (refer to the list on the back of each survey form)
Please ensure we have county of residence (or province / country if non-resident of NS).
Complete admission date, discharge date (if applicable) and whether the patient was discharged alive.
Please choose only one (best) response to each of the multiple option questions except where indicated.
Note that some affirmative responses require the completion of a date.
For responses in the "other" category – please provide a brief explanation in the space provided.

When Should the Survey be Completed?

The survey strategy has two phases:

- For a two week period chosen by the participating hospital, survey forms are to be completed at the **time of discharge** on each patient who meets the inclusion criteria set out below.
- **On the last day of the survey**, forms are to be completed on all discharges who meet the inclusion criteria, PLUS, **all patients still waiting in the hospital** who would meet the inclusion criteria if they had been discharged on that last day.

Special note re deceased patients – if they meet the criteria below, treat them as you would a regular discharge.

Inclusion Criteria

Two questions must be asked to determine whether a patient should be included in the study or not:

- First, Is the patient making a transition to a different level or location of care (Discharge to nursing home, homecare, transfer to another hospital, *etc.*) ?

  OR

  Could the patient make a transition to a different level of care if certain services were available outside the acute care setting?

- Second, Has the patient been waiting for a period of greater than twenty-four hours for the required/needed care to become available?

Questions

1. Is the patient being, or should the patient be, transferred or discharged to another level of care (after waiting >24 hours), and if included per the study criteria above, where would they go?

1.A Answer **yes** if they are being discharged after waiting >24 hours, or if on the final study day they are still waiting.

For Tx/Dx	Transfer for diagnostic/treatment services not available in facility
Post Tx/Dx	Transfer after diagnostic/treatment services have been provided
NH	Nursing Home
Other LTC	Other long term care program operated by the Department of Community Services including: Regional Rehabilitation Centres, Adult Residential Centres, Group Homes, Residential Care Facilities, and Community Based Options (incl. Small Option Homes)
HC	Home Care
SH	Supportive Housing: Enriched living, Assisted Living
Family	Care by family
Self	Care by self

1.B Answer **"yes, but"** for chronic, long-stay patients who are ineligible for current post-discharge services by reason of a high level of care/supervision, etc, or because of residency requirements, if you think they should receive another level of care, but such services are not currently available. Please indicate the main reason:

Physical Problems	Main problem involves a physical diagnosis
Mental Health Problems	Main problem involves a psychiatric diagnosis
non NS resident	Non resident and therefore not eligible for services in NS

1.C **Additional resources required for discharge** – What additional community resources would be required for the patient to be discharged from your facility? Place a check mark beside those resources that are critical to being able to discharge this patient from an acute care setting and circle the option that you judge to be the single most important factor.

Higher HC limits	Care requirement exceeds current Home Care maximums
Supervision	May not require specific care but unsafe or inappropriate to be left alone
GP Post-D\C	Doesn't have a family physician to assume care in community
Meds/Supplies	Cannot afford or obtain necessary medications/medical supplies post D/C
Palliative HC	Palliative home care services
Hospice	Hospice Care
Respiratory Therapy	
Physio/OT	Physio or Occupational Therapy

Social Supports	Lacks family / friends who could assist with care/supervision needs
Mental Health Services	Intensive community-based mental health treatment and support

2.A **Actual/est. date patient was ready** - Insert the date you know or estimate the patient would have been capable of being discharged had the required resources been available.

2.B **Formal process begun (notice to assessor)** For patients where an external process (*i.e.* classification for LTC or assessment for homecare) must take place, please insert the date that the initial documentation was completed and the external assessors notified. We will be using this date and the assessment date in Question 3 to determine the response time by LTC/HC assessors, so, in order to be fair, please try to indicate the date on which they were notified.

For patients where a formal external process is not involved, please estimate the date that the patient could / should have made a transition to a different level of care. Special cases: Inter-hospital transfer – use the date a bed was requested in the other hospital. Chronic long stay patients – estimate the date their condition stabilized and they started receiving care intended only to maintain them in their current state.

3. **Has this patient been assessed by LTC/HC/Other?** Many discharge processes require assessment by external organizations, e.g., LTC assessors, Home Care assessors. If the patient has been assessed, we would like to know the date the assessment was started, *i.e.*, forms & patient were reviewed, *etc.*

Answer *no* if the assessment has not started, or if no external assessment is required.

4. **Status of Assessment / Classification** This question allows you to indicate whether assessments / placements are still "in process," or to provide the results of a completed assessment. If a classification has taken place, please provide the date of classification, regardless of result.

Care req. too low - Judged to have care requirement too light to require nursing home
Care req. too high - Care level too high - Judged to have care needs beyond Level II capacity

Classified, awaiting placement - Patient has been classified as appropriate and is waiting for an opening in an appropriate facility. Please provide the date the classification took place.

Response to placement offer by patient or family.

5. **What funding is required for placement?** Please indicate the source of funding if the patient will be accessing a Nursing Home or similar arrangement.

Finally, please enter the form completion date, identify yourself, and give us a number where you can be reached if we have a question about the survey form.

— Thank you very much for your cooperation —

Nova Scotia Department of Health
Facilities Review
ADMINISTRATIVE PROTOCOL

Structure:

- The Review will cover the study period November 9 to December 6, 1999.
- Each Region/NDO will choose the 14–day period (Tuesday to Monday) that is best for them within the study period.
- There will be one contact person per Region/NDO who will be responsible for ensuring that all facilities (sites) within the Region/NDO have completed and returned the required documentation.
- There will be one contact person at each facility (site) who will be responsible for ensuring that a questionnaire has been completed on each eligible patient and for the daily/ final collection of documents. This person will work with those who are involved with direct patient care and discharge planning to identify all persons in the facility who meet the Inclusion Criteria: Discharge Planners, and/or Social Workers, and/or Charge Nurse, and/or Home Care Assessors, and/or Long Term Care Coordinators.
- A Health Records/Admitting staff person will be the contact at each facility to complete the census form for the study period.
- Workshops will be held in each Region/NDO prior to the start date for the facilities involved.
- The questionnaires will be distributed during the workshop. The workshop is designed to clarify the process, ensure consistency in reporting and give an opportunity to ask questions. Where the Workshop is done by conference call, the material will be sent prior to the workshop date.

Data collection:

Daily Census:

- This is to be completed for the study period, November 9th to December 6th, 1999, by the designated Health Records/Admitting staff. The persons responsible for census information will be contacted by Barb Harvie. A census form will be provided prior to the start of the study period. Completed census forms are to be faxed to (902) 424-0663.

Questionnaire:

- Each day of the study period, the questionnaire will be filled out for EVERY PATIENT BEING DISCHARGED who meets the Inclusion Criteria (i.e., all patients discharged at any time in the 24–hour period). Please follow the document *Guide to Responses to Discharge Planning*

Questionnaire provided. If questions arise, please contact Pauline MacDonald, (902) 424-0963, for clarification.

- On the last study day, a questionnaire will be completed for EVERY patient in the facility who meets the inclusion criteria (including discharges).

- The first report from the Regions/NDOs will be sent by courier to the N.S. Department of Health on survey–day #8 (Tuesday). This is the information up to and including day #7, Monday. The second report will be sent by courier on the Tuesday following the last day of the two–week survey period. Call Priority Post Courier Service at 1-800- 661-3434 for pick-up. Enter customer account # 03190382 and send to:

  N.S. Department of Health
  Acute Care Programs
  Joseph Howe Building
  1690 Hollis Street
  Halifax, N.S. B3J 2R8
  Attention: Pauline MacDonald (424-3931)

Data Analysis:

- Data will be entered into Epi Info #6, an Epidemiology data base, by staff at the Department of Health.
- Data will be analyzed by Department of Health staff, Health Information and Evaluation Section.
- The report will be sent to the Region/NDO contact persons and the CEOs for validation before presentation to the Deputy Minister of Health.
- The report will be presented to the Deputy Minister of Health upon completion.

November 3, 1999

Nova Scotia
Department of Health

Telephone: (902) 424-0972
Email: harviebj@gov.ns.ca
Telephone: (902) 424-3078
Email: aucoinml@gov.ns.ca
Fax: (902) 424-0663

HEALTH SERVICES SUPPORT BRANCH

MEMORANDUM

TO: Facility Census Coordinators

FR: Barb Harvie & Maureen Aucoin

DT: November 4, 1999

RE: COMPLETION OF CENSUS FORMS FOR NOVEMBER 9 TO DECEMBER 6

Enclosed are the four weekly census forms you have been asked to complete to supply the information needed for the Facilities Review Process. Regional and Facility Coordinators will be responsible for the completion of survey forms on patients waiting for discharge but it is also important to know how many beds were available (staffed and open) and how many were occupied during the entire month of the survey. You have been identified by your regional/site coordinator as the individual who will ensure that your facility's census data are completed.

These census forms should be faxed to us (Barb and Maureen) at 424-0663 by noon on the Tuesday following the end of each census period, e.g., the first week's (November 9 to November 15) census information is due on Tuesday, November 16.

Please indicate on the form the number of patients occupying a bed on each day of the census report and the number of staffed and open beds. Your 'staffed and open' numbers may change from day to day if, for example, your facility has weekend closures.

You will notice that the groupings are very general - the first section Med/Surg/ICU/Paeds/GAU/Gyn includes your acute care medical and surgical beds, any ICU, CCU, step-down unit beds, geriatric assessment unit, and gynecology unit beds. Obstetrical and Mental Health Unit beds are listed separately. If your facility has in-house Addiction Programs, please indicate the number of patients and bed numbers. Long Term Care beds are those beds designated as LTC and should include VAC beds. The 'other' groupings are provided to allow you to indicate volumes in any units/services that you wish to record separately. Specialized facilities may want to adapt the headings to meet individual needs, e.g., the IWKGrace is using an 'other' section to indicate its neonatal unit.

Please don't hesitate to call either of us (Marueen at 424-3078 or Barb at 424-0972) with any questions that you may have.

cc: Regional Coordinators (this memo only)
Pauline MacDonald, Acute Care Programs, NS DOH

g:\research\harvie\memos\censusnov.4

FACILITY CENSUS SITE COORDINATORS

EASTERN REGION	NORTHERN REGION	CENTRAL REGION	WESTERN REGION	NDOs
Patricia Aucoin Sacred Heart	Doris Benjamin South Cumberland	Sharon Barter Dartmouth General	Mary Veniot	Jimi Kaye QEII
Neeraj Bhanot St. Mary's	Jane Caldwell Bayview	Trudy Bennett Twin Oaks	Sandy Gibbons Valley Regional	Paula Allen - Admitting: IWK/Grace
Elaine Cameron Strait Richmond	Janet Canfield Lillian Fraser	Gail Bennison Musquodoboit Valley	Elizabeth Sheppard Soldiers Memorial Annapolis Community Digby General	Linda Hammond/Sharon Warwick NS Hospital
Ruth Fraser Victory County Memorial	Brenda Carpan Sutherland Harris	Marie Cole Hants	Alice Robbins Yarmouth Regional Roseway General	Margaret MacDonald CBHCC
Claire Hatcher Buchanan Memorial	Diana MacDonald Aberdeen	Beverley Smith Eastern Shore	Susan Walters Health Services Associaton - South Shore Site/Fishermen's Site: Queens General	
Brenda MacDonald Inverness	Beryl MacLean North Cumberland			
Bernadette Murray Guysborough	Charlotte Smith - Colchester			
Susan Roberts Eastern Memorial	Margie Smith All Saints			
Marsha Wong - St. Martha's	Margie Smith Highland View			

Date	Med/Surg/ICU/ Paeds/GAU/Gyn		Obstetrics exclude bassinets		Mental Health		Addiction Programs				Long Term Care		Others - Specified				Other - Please ID		Other - Please ID	
							Detox		28-day				Restorative Care		Rehabilitation					
	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open
November 9																				
November 10																				
November 11																				
November 12																				
November 13																				
November 14																				
November 15																				

Facility/Site Name: _____

Census Report Completed by: _____

Phone Number at which you may be contacted for any questions: _____

Please identify the number of staffed beds, i.e., beds in operation on each day of the survey. The number may change during the survey period.

***Separate totals** should be reported for*
***medical/surgical:** including ICU/CCU, step-down, paediatrics, etc.*
Obstetrics - excluding bassinets
Acute Psychiatric/Mental Health beds

Instructions: Please fax this completed census form by noon, Tuesday November 16 to Barb Harvie/Maureen Aucoin at 424-0663

Questions should be referred to Barb (424-0972) or Maureen Aucoin (424-3078) in Health Information at DOH.
Facilities are encouraged to adapt this form to meet their particular needs, e.g., you may want to ID the number of patients waiting in the ER for beds.

Appendix 5

Review Time Table

Transitions in Care

N.S.D.O.H. Facilities Review

Review Time Table

Workshops/Education Sessions	Date
Central Region	November 10 & 16, 1999
Cape Breton Healthcare Complex	November 9, 1999
Eastern Region	November 8, 1999
IWK/Grace Health Centre	November 2, 1999
Northern Region	November 9 1999
Nova Scotia Hospital	November 10, 1999
QEII Health Sciences Centre (4 wkshps)	November 17 & 18, 1999
Western Region	November 8, 1999

Hospital Review	Date
Central Region	November 23 - December 6, 1999
Cape Breton Healthcare Complex	November 16 - November 29, 1999
Eastern Region	November 23 - December 6, 1999
IWK/Grace Health Centre	November 9 - November 22, 1999
Northern Region	November 16 - November 29, 1999
Nova Scotia Hospital	November 16 - November 29, 1999
QEII Health Sciences Centre (4 wkshps)	November 23 - December 6, 1999
Western Region	November 16 - November 29, 1999

Annex #2

Physician Consultation Report

MEDICAL APPENDIX TO FACILITIES REVIEW

In October 1999, Drs. Ross Langley and Murray Nixon visited 34 acute care facilities throughout the province as an initial step in the facilities review. They met with the Chief of Staff and/or the President of the Medical Staff of each facility and left a questionnaire for them to complete and return. Thirty four completed questionnaires were received. The following is a summary of the responses.

1. All 34 physicians would be willing to be part of a medical network during the 90 day facility review and follow-up studies.

2. 32 physicians considered the review protocol (which was at an early phase of development) to be satisfactory. Two were undecided.

3. Suggestions for improvement of the review process included:
   - Availability of data on length of stay, outcomes and utilization.
   - A longer time frame.
   - Inclusion of site manager, nursing staff and other health care professionals.

4. The average time on a waiting list for admission to community and secondary care facilities was estimated to be:
   - A few days for pediatrics.
   - A few days to weeks for medicine
   - Weeks to months for surgery

5. Specific waiting list problem areas fell into certain categories.
   - Patients occupying a hospital bed awaiting a nursing home bed, including patients awaiting readmission to a nursing home.
   - Subspecialty procedures.
   - Psychiatry.
   - The large number of admissions through the emergency department.

6. The major problems faced by emergency departments were repeatedly identified as:
   - Overcrowding and long wait times in large part due to the poor public appreciation of the role of the emergency department and the lack of availability of private physicians. There are too many patients who should be at an alternate site, i.e. Doctor's office, too many patients without a primary care physician and too many beds in emergency departments occupied by patients awaiting hospital admission. Patients are being managed as outpatients for follow up treatment in the emergency department e.g. DVT, IV antibiotics.

   - Staffing shortages. Not enough physicians to take call rota. Nursing shortage makes calling in extra staff difficult, lack of x-ray and laboratory technicians for call back services. The unavailability of x-ray and laboratory services after hours results in transfer of patients to other facilities to complete their care.
   - Insufficient home care resources. Home Care needs to be available as soon as possible especially on weekends to assume community management in a seamless manner.

- Deterioration in quality of equipment.
- "I could write a book about this! Try inadequate space, staff (both medical and non-medical) and equipment for a start."

7. There was consensus that the following services should be available in secondary care facilities:

   - Internal Medicine
   - ICU/CCU
   - General Surgery
   - Pediatrics
   - Obstetrics
   - Echocardiography
   - Stress Testing
   - Pulmonary Function
   - Oncology
   - Otolaryngology
   - Orthopedics
   - Ophthalmology
   - Urology
   - Colonoscopy
   - Endoscopy
   - CT

   Opinions varied on the inclusion of:

   - ERCP
   - Geriatrics
   - Rehabilitation Unit
   - Chronic Care Unit (Level 3)
   - Nuclear Medicine

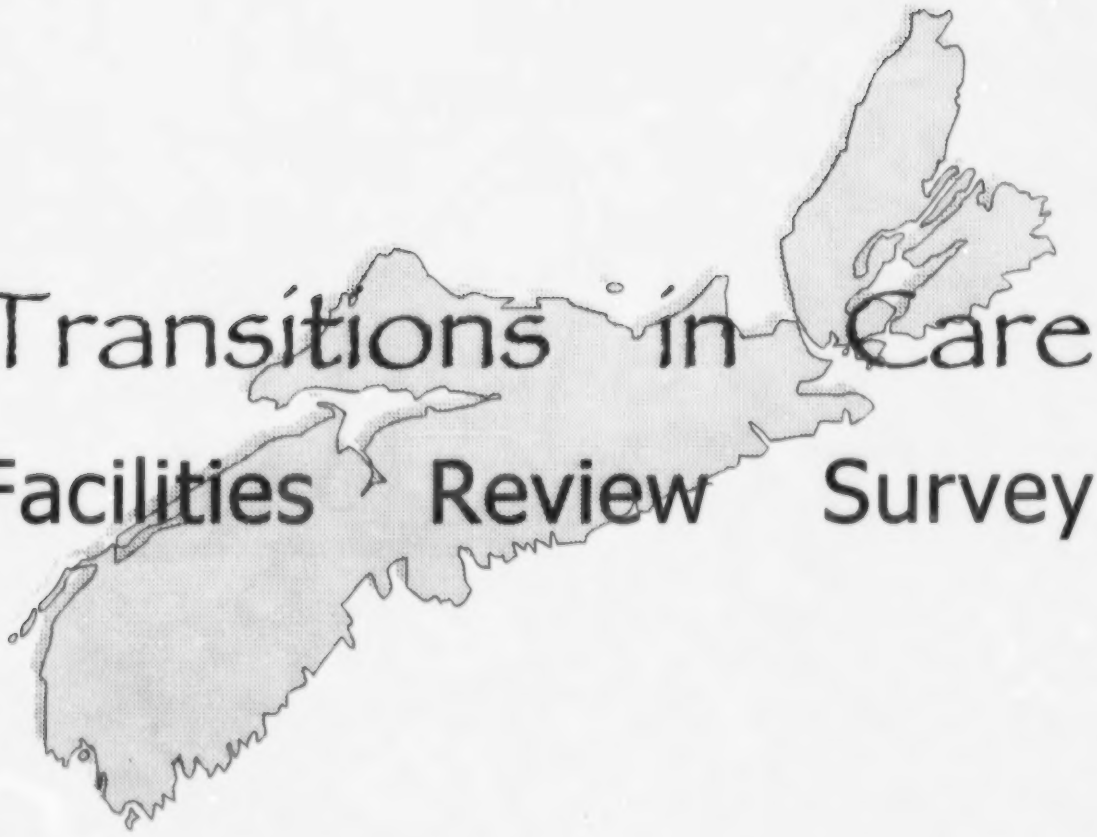
8. The individual forms completed by the Chiefs of Staff and Presidents of the Medical Staff are available on file.

Ross Langley and Murray Nixon would like to thank the participating physicians for their thoughtful opinions, cooperation and collegial reception.

Prepared by: Dr. Murray Nixon
Department of Health

Annex #3

Facilities Review
Phase II Report



Transitions in Care

Facilities Review Survey

Transitions in Care
Facilities Review Survey

Prepared by the Nova Scotia Department of Health
February 28, 2000

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This report is also available in Adobe Acrobat® format on the Nova Scotia Department of Health Website at http://www.gov.ns.ca/health

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Acknowledgements

The Facilities Review Survey is that part of the Health Facilities Review Process that focussed on a survey of the acute care sector in Nova Scotia. Numerous persons and organizations contributed to the development and implementation of the Facilities Review Survey, but specific note should be made of the contributions of the following:

- The Survey Core Team, Elizabeth Barker, David Elliott, Barbara Harvie, and Pauline MacDonald;
- Discharge Planning staff at Dartmouth General who reviewed the questionnaire in its early stages;
- The QEII Health Sciences Centre group convened by Dr. Brendan Carr for their critique;
- The Cape Breton Healthcare Complex for the pilot test of the questionnaire;
- Regional CEO's for their cooperation;
- Facility coordinators, the census contacts and the staff who completed the surveys;
- Peggy Gorman for sharing her time and expertise to be the clinical contact during the survey period;
- Debbie Carew and Clara Boyd for data entry; and,
- David Elliott and Pauline MacDonald for the analysis and writing of the report .

If any contributions have been missed inadvertently, please accept this apology. The survey involved a phenomenal effort by numerous participants and all contributions were valued and the core team wishes to thank those who advised the process, completed questionnaires and provided the linkages to ensure that all surveys were received, followed up and properly counted.

Table of Contents

List of Figures

Chapter 1
Introduction

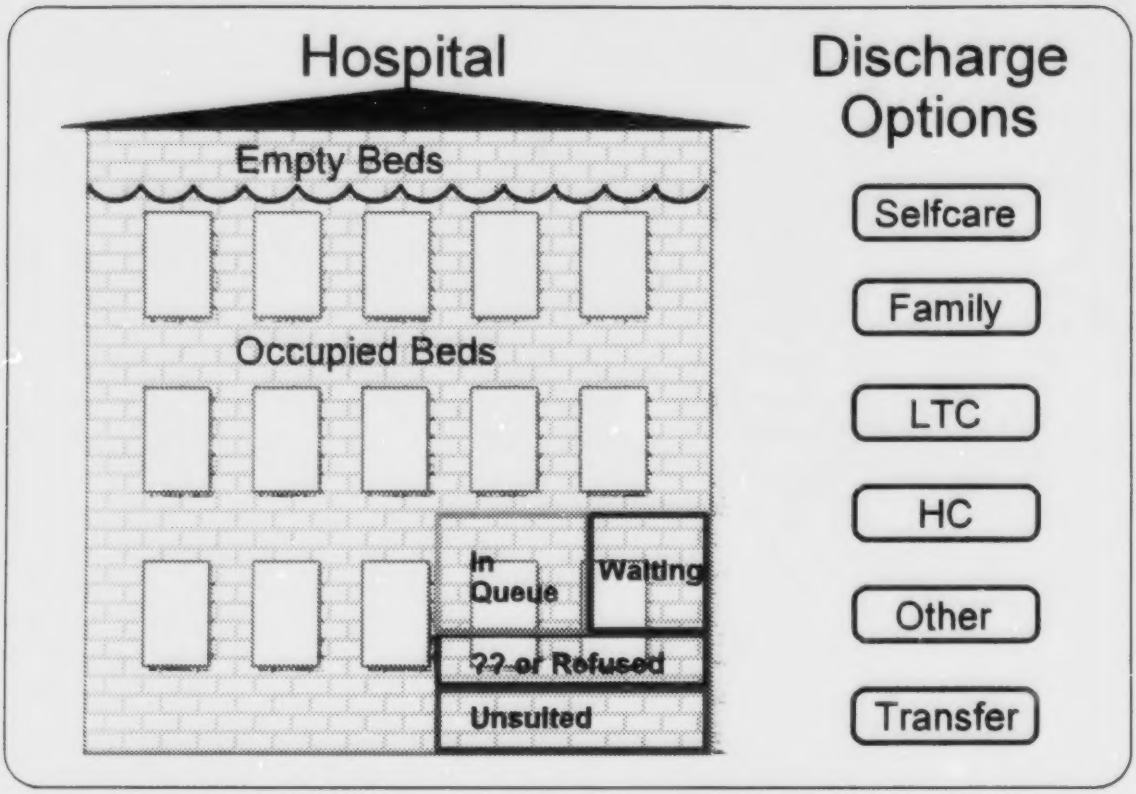
> *In partnership with health care providers, immediately undertake a comprehensive assessment of all health care facilities in order to ensure that Nova Scotians are receiving the right type of care in the appropriate facility.*

1.1 Rationale for a Facilities Review Survey

The campaign pledge quoted above was the impetus behind the facilities review process carried out by the Department of Health with the cooperation of Nova Scotia's hospitals and Health Boards. Due to the time constraints imposed by deadlines in the pledge, a phased approach was taken. Phase I reviewed the existing "state of the art" of utilization review efforts in Nova Scotia hospitals. The Phase I report was available in November 1999.

Phase II is the current study which provides a two-week survey "snapshot" of all acute care facilities, identifying the various obstacles to transition between different levels of care that existed during the survey period. The data gathering for this review took place between November 9th and December 6th, 1999.

One of the needs identified during the Phase I study was for consistently defined and executed utilization information allowing capture of a wide range of patient circumstances, including identification of patients requiring resources that were not currently available in the community. This required development of a new survey instrument and methodology to capture pertinent information with optimal timing.



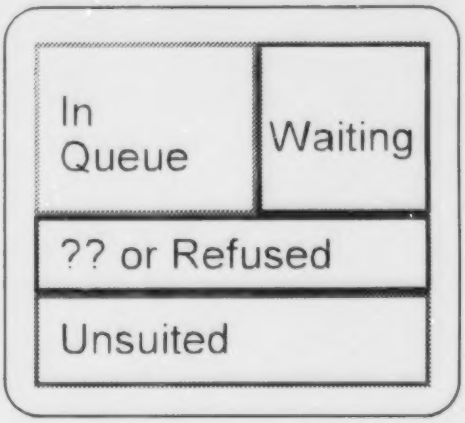
1.2 Conceptual Model

Hospital utilization and occupancy is a function of the number of persons admitted per unit time and the number of discharges per unit time. For purposes of this review, we are particularly interested in the discharge component, especially for those persons who no longer require active investigation or treatment. A conceptual model of the various information components is illustrated above. At any time, a proportion of a hospital's patient population will no longer require acute care services and may be considered to be in transition to another level or location of care. Quantifying this population and determining reasons for delays in these transitions are the underlying purposes of this review.

1.2.1 "Opening the Box"

The aim of the review is to, in part, open up the box representing the lower right corner of the diagram. The number of persons normally occupying this box is determined by a combination of their relative care needs and the community capacity to meet those needs outside the acute care facility environment.

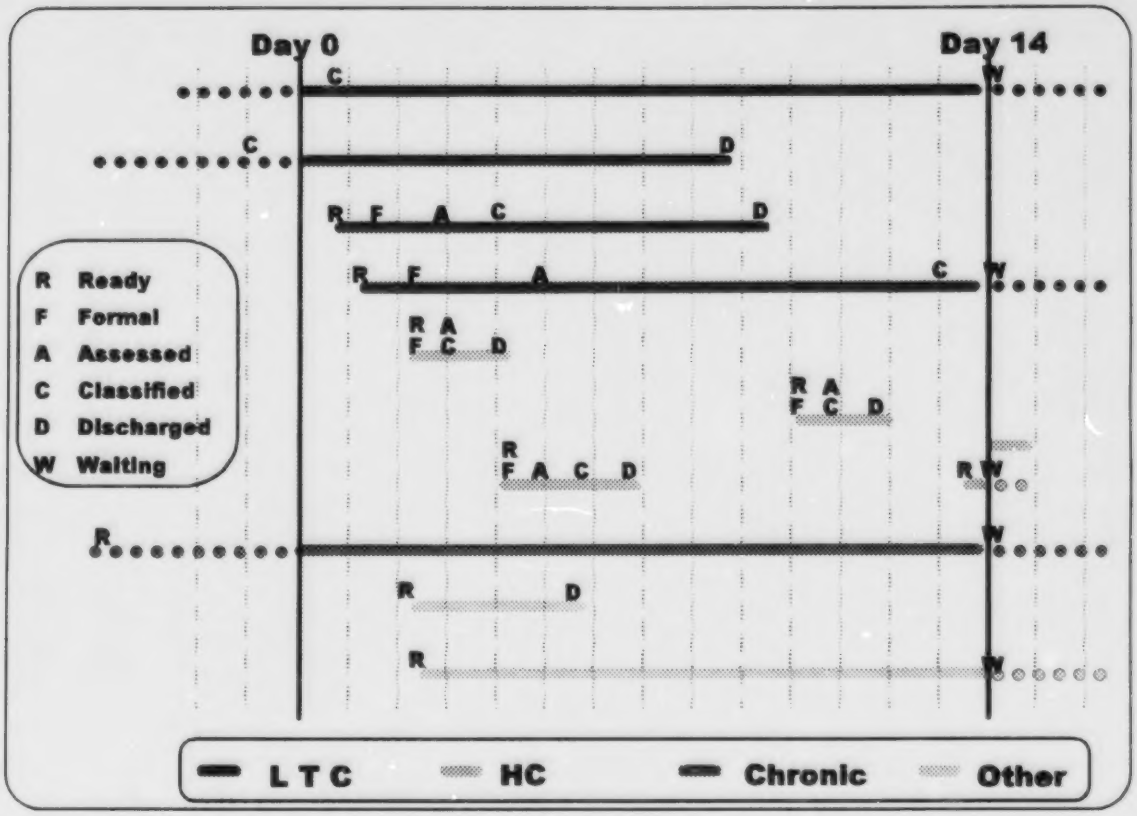
The components include persons whose discharge planning process has started and are "in queue" or persons who have been approved for a discharge option but are waiting for the resource to become available. In addition there are persons whose acceptability for a discharge option is in question or who have refused an offer of placement in the community. Finally, there are persons who, for reasons of physical or mental health problems requiring a chronic high level of maintenance care, are judged unsuited for placement in the community, given current options or resources.



1.3 Chronology

As persons move through various stages of the discharge planning process, certain critical events can be recorded starting with the date they were ready for discharge. If their discharge requires some form of external review, for example, for nursing home placement, the steps of formal notification, assessment, and classification must all be completed before discharge can take place, and the respective dates recorded. This allows development of a chronology on each person as they move through the system. It is important to identify the proportion of persons in each of these stages in order to focus on and correct bottlenecks that may exist. The stages may be further characterized by identifying for which resource the person is waiting.

A hypothetical chronology of a number of persons in hospital during a two time period is diagrammed on the following page. (LTC= Long Term Care and HC = Home Care)



In the illustration above, patients waiting for Long Term Care (LTC), Home Care (HC), with chronic mental health or physical problems (Chronic), or with other circumstances leading to a wait in hospital (Other) are represented by the horizontal lines. Many of these patients go through a process where they are judged ready for discharge (R) and a formal notice is given for an assessment to be performed (F). The Assessment may be performed (A) resulting in a Classification (C). These various stages may all be recorded as dates, and the number of days in each stage constitutes a waiting time. In the case of Home Care, the process may be quite quick, with the entire process completed in one or two days, while the stages of a discharge to Long Term Care may be prolonged. Persons with chronic problems may have no discharge prospects given the current level of community resources.

Chapter 2
Methods

2.1 Process

The underlying process used in this survey is similar to the"A day in the life" approach that has been used in various facilities to create a snapshot of hospital utilization. This method can be employed to give a general profile but might miss random events, especially in smaller facilities. As a result, a longer, 2-week time period was chosen to ensure a larger sample. The time period was determined by a number of factors, including the need to get results promptly, the workload on facilities, other processes at the facility level, including accreditation and restructuring of clinical services.

Due to the operational concerns of a number of hospitals it was impossible to run the survey concurrently in all sites. As a result, implementation was staggered over a three week period. All data collection started at 0001 hrs on a Tuesday and concluded 14 days later at 2400 hrs on a Monday.

2.2 Census

A Census process was developed to collect bed availability and utilization data during the study month (not just the two weeks of the site survey administration). Beds available were defined as staffed and open while beds used were defined as beds occupied as of midnight of the day recorded. Beds were broken down by service where appropriate in multi-service hospitals. Census data was accumulated daily and forwarded on a weekly basis. The data were entered into a spreadsheet and graphed to provide trend information as well as transferred to a database for use with the survey data. The tabulated data were reported back to the sending institutions for error-checking and clarification where necessary.

2.3 Questionnaire

A questionnaire was developed to gather basic demographics and to capture a range of situations where a period of waiting prior to making a transition to another level of care took place. This included:

i. Transfer (before or after definitive treatment services)
ii. Provincially-funded programs (Department Community Services Facilities, Nursing Homes, Home Care)
iii. Private arrangements (Family, self care, special housing)
iv. Problems preventing or delaying discharge (Mental or Physical Health Problems)
v. Other

Questions were also directed at the various stages when there was a process of application, assessment and classification to access a particular resource. When there were specific results from these stages, the results and associated reasons were also captured. The questionnaire is included as Appendix 2.

2.3.1 Consultations

Consultations were carried out with a number of external groups:

i. Dartmouth General Hospital
ii. Nova Scotia Hospital
iii. IWK Grace Hospital
iv. Northern Region
v. QE II Health Sciences Centre

Their input was critical to assuring the survey instrument addressed the needs of both general and specialized patient populations. In addition, while the original intent of the survey was directed at the Nursing Home / Long Term Care sector, the importance of patients awaiting inter-hospital transfer was emphasized by the consultation participants and incorporated into the instrument.

In addition, a one-week pretest of the survey instrument was carried out at the Cape Breton Regional Health Care Complex.

2.3.2 Inclusion Criteria

Critical to the execution of the survey in a uniform fashion across the province was development of clear inclusion criteria. This proved to be the single most difficult task in the survey process. The following diagram illustrates the inclusion criteria that were finally accepted in the form of three questions.

Is the patient making a transition to a different level or location of care (Discharge to nursing home, homecare, transfer to another hospital, etc.) ?	O R	Could the patient make a transition to a different level of care if certain services were available outside the acute care setting ?

AND

Has the patient been waiting for a period of greater than twenty-four hours for the required/needed care to become available ?

Criteria were developed that included all patients no longer requiring acute care services who were waiting to make a transition to another location or level of care, but had been waiting to be discharged for a period in excess of 24 hours. The criteria were broadened to include persons who, given appropriate community resources, might be discharged since, in the view of hospital staff, they did not really require the services of an acute care facility.

These inclusion criteria were discussed in detail in an orientation kit provided to all site coordinators and a brief version was provided on the reverse of every survey form for quick reference. (See Appendices 2 and 3)

2.4 Sampling

The basic sampling strategy was a 100% sample exit survey completed at time of patient discharge. This means that, for every patient meeting the inclusion criteria above, the survey would be completed at time of discharge by the appropriate hospital staff. The survey was also completed on patients meeting the inclusion criteria but still in hospital on the last survey day.

Based on expected numbers of persons with >24hr waits in their discharge process, either from anecdotal reports or the results of utilization reviews carried out by a number of hospitals, a response of between 600 to 1200 questionnaires was anticipated. This was further confirmed by examination of monthly hospital reports to the Department of Health regarding the numbers of persons waiting for long term care. The unknown factors were persons awaiting transfer and persons with problems where no attempts were being made to discharge.

2.5 Training Sessions & Access to Assistance during Study

To ensure that all hospitals were providing comparable data, training sessions were held to familiarize the participants with the survey tool and answer any questions that might arise. There were three Department of health staff who were involved in the development of the survey tool. In most cases, two of the three would be present at each workshop. For the four workshops presented at the QEII Health Sciences centre and the workshop at the IWK Grace Health Centre, all three were present.

The only region that did not receive an in-person workshop was Western Region where a conference call involving representatives from each facility was the format used. This proved less effective than the in-person sessions, since generally one or more follow-up phone calls were required with the Western Region sites.

Region/NDO	Workshop Date	Survey Dates
IWK Grace Health Centre	Nov.2, 2:00pm, IWK Grace	Nov. 9-22
Cape Breton Health Care Complex	Nov. 9, 9:00, CBHCC	Nov. 16-29
Northern Regional Health Board	Nov. 9, 12-1:00, Truro	Nov. 16-29
Nova Scotia Hospital	Nov. 10, 10:00 , NSH	Nov. 16-29
Western Regional Health Board	Nov. 8, Conference Call, 1:30-2:30	Nov. 16-29
Central Regional Health Board	Nov 16,Twin Oaks Hospital Nov 10, Windsor Conference Call, 2:00	Nov. 23-Dec. 6
Eastern Regional Health Board	Nov. 8, 11:00, Straight Richmond Hospital	Nov. 23-Dec. 6
QEII Health Sciences Centre	Nov.17, 10:00-11:00; 2:00-3:00; VGH Site Nov. 18, 10:00-11:00, 2:00-3:00, HI Site	Nov. 23-Dec. 6

There were two persons available to answer questions throughout the survey period. First was an RN familiar with discharge planning and utilization management techniques and tools. This RN was available by telephone to answer any questions of a clinical nature throughout the survey period. The contact person for questions of an administrative nature was one of the three involved in developing the process.

Each participant received a folder with the following:

i. List of facility census site coordinators
ii. Instructions on completion of census forms
iii. An administrative protocol with detailed instructions of when, where and how to forward the completed information, and contact names and numbers
iv. A copy of the questionnaire

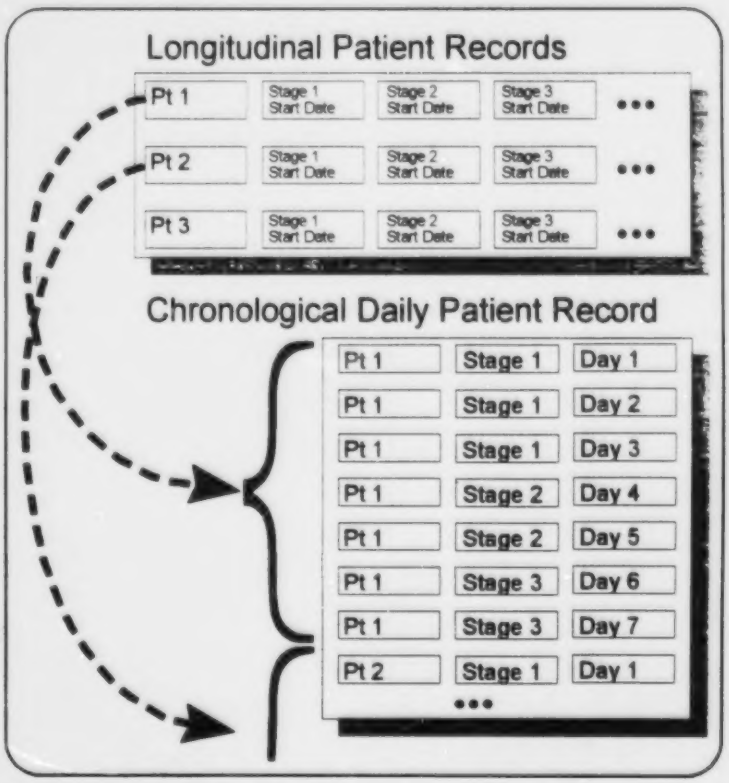
v. A "Transitions in Care" questionnaire guide with detailed instructions of how to complete the questionnaire.

2.6 Data entry

Data entry was performed using the EpiInfo database and statistical program. An entry program with extensive edit checking was developed to both streamline data entry and provide comprehensive detection of inconsistencies, especially in date sequences. A single person did the majority of data entry, and reviewed all entries done by a second data entry person.

2.7 Analysis

The data were converted from EpiInfo for use in FoxPro 2.6, Cognos Powerplay, and Statistica.



A database program was developed to expand the longitudinal data from individual survey forms into a series of daily chronological patient records recording the resource the patient was waiting for and the stage of progress (assessment, classification, etc.) reached. The longitudinal records allowed calculation of waiting times for various resources while the chronological records allowed analysis of the number of patient days were being utilized during any particular time period while waiting for a resource or while in a particular stage of the discharge process. These daily records allowed creation of daily and weekly hospital patient profiles expressed as patient days awaiting a particular resource.

Chapter 3
Results

3.1 Response

Eight hundred and seventy three responses were received. All completed questionnaires were read for errors and compliance with the inclusion criteria. Errors or omissions were followed up by telephone contact with either the site coordinator or the person who had completed the questionnaire.

Total and Valid Responses

	Rejected*	Remaining
Received		873
Rejected Prior to Entry	30	843
Rejected After Entry	25	818
Rejected During Recode**	7	811

* Response was out scope according to inclusion criteria.
** Recoding is explained in section 3.2

3.1.1 Rejected responses

Responses were rejected as being out of scope for a number of reasons. They may have been outside the survey period, the waiting period was < 24 hours or the patient was receiving active treatment at the time the questionnaire was completed. During analysis further inconsistencies were discovered in some responses leading to them being excluded from the final analysis.

The table at the upper right summarizes the number of responses and the number rejected for being out of scope. The number of valid responses by region of hospitalization is summarized in the second table at the right.

Valid Responses by Region and Percent of Total Responses

	Count	Percent
Northern	97	11.9
Western	159	19.4
Eastern	261	31.9
Central	301	36.8
Total	818	100.0

3.2 Recoding

Despite the availability of checkboxes on the questionnaires indicating which discharge option was being waited for, respondents frequently chose "other" as a response, but then went on to correctly indicate, in text, the appropriate resource. The number of "other" responses was unacceptably high and all questionnaires and text were scrutinized and, wherever possible, the "other" response was substituted with the resource identified in the accompanying text. Minimal recoding of responses other than "other" was necessary. The following table indicates the recoding of the "other" category by region.

The majority of "other" responses could be classified as some form of Long Term Care, nursing home, or home care, while physical and mental health problems comprised the majority of the remaining recodes.

The coded responses were then aggregated into broader groups as follows:

Transfer
- Before Treatment
- After Treatment

Provincially Funded Programs
- Nursing homes
- Department of Community Services Facilities
- Home Care
- Group Home

Private Arrangements
- Selfcare
- Family
- Special housing

Problems preventing or delaying discharge
- Physical problems

Recoding of Category "Other"

	Regions				
	Northern	Western	Eastern	Central	Totals
After Treatment	0	0	0	1	1
Family	2	3	7	5	17
Transitional Care	0	0	0	1	1
Special Housing	0	0	1	4	5
DCS Facilities	2	4	9	29	44
Selfcare	2	0	1	4	7
Excluded	0	4	1	2	7
Physical probs	9	9	23	18	59
Home Care	2	3	10	6	21
Mental health probs	3	0	5	10	18
Nursing Home	6	2	8	11	27
Other	9	15	12	12	48
Pre Treatment	3	2	6	0	11
Group Home	0	0	0	4	4
Question	1	1	0	1	3
Restorative Care	1	0	0	0	1
All Groups	40	43	83	108	274

- Mental health problems

Other
- Other problems preventing or delaying discharge
- Questionable response - not classifiable

3.3 Distributions According to Resource

All analysis is presented at the provincial or regional level. Regional breakdowns are geographic and include their associated NDOs. Further detailed breakdowns can be made available to regional, NDO, or individual hospital authorities upon request. However, given the small numbers of responses associated with some institutions, it would be inappropriate to include in this report a more detailed breakdown that would identify individual hospitals.

3.3.1 Responses

The distribution of survey responses according to resource by region summarized in the table below. Provincially funded programs comprised the largest number of responses in all regions, ranging from 44% in Northern to 60% in Eastern.

Distribution of Survey Responses According to Resource

	Transfer	Province	Private	Problems	Other	Totals
Northern	20	40	6	15	15	96
Western	33	84	7	15	16	155
Eastern	32	156	24	35	12	259
Central	50	141	27	65	16	299
All Groups	135	421	64	130	59	809

3.3.2 Patient Days

When looked at according to patient days, the provincially funded programs comprise an even larger portion of the total days, ranging from 54% in Northern to 70% in Eastern. The patient days are further broken down within each of the aggregated categories in a series of bar graphs.

Waiting for Transfer

Patients waiting for transfer before treatment are present in all regions. However, Central has a far larger portion who are post treatment and awaiting transfer, presumably back to the patient's local hospital.

Provincially-funded Programs

Only a small number of patient days are utilized by patients awaiting homecare services. The largest portion in all regions is the group waiting for nursing home placements. In Eastern the nursing home group utilizes far more patient days than the other groups.

Private Arrangements

The distribution within this category varies among the regions. In Northern and Western there were no patients waiting for special housing. Because of the small numbers involved, no conclusions should be drawn regarding the comparative availability of special housing arrangements between regions. Likewise, the absence of persons in the selfcare category in Western region may be entirely due to chance and the limited study period.

For the two regions, Eastern and Central, with large numbers of patient days classified as private arrangements, Eastern has a much larger proportion of persons being discharged to care by their family. This may represent a regional difference in underlying family/social structure between the regions, *e.g.* more extended families in Eastern region, or could indicate a relative unavailability of other options in Eastern.

Patients with Problems

This category contained patients who either were chronically hospitalized because of their health problems, or proved to be a challenge to place in the community. Central region has a large portion of persons with mental health problems, probably reflecting the presence of a tertiary psychiatric facility.

3.4 Proportion of Patient Days according to Resource

Analysis of the patient days according to the resource for which the patient was waiting as a proportion of the total beds used or beds available was performed to illustrate the "load" on the system represented by each category. The results of this analysis are presented as a series of graphs representing overall provincial distributions and regional breakdowns.

3.4.1 Overview

Figure 3.1 expresses the proportions of persons in acute care and each of the "waiting" categories for the entire province during the two weeks of the survey period, while Figure 3.2 provides a similar picture with by region of hospitalization. Overall, one quarter of patient days during the two week study period involved persons waiting for some form of resource. On a regional basis, the proportion ranged from a low of 18.9% in Central region to a high of 37.8% in Eastern region. The single largest difference between regions was in the "Provincially funded" category where Central region had only 10.6% compared with Eastern region's 26.2% of patient days.

3.4.2 Transfers

Transfers are shown in Figure 3.3 and are divided into patients where the definitive diagnostic or treatment services have been provided and the wait is for return to a hospital closer to home, or patients waiting for definitive care in another hospital having the required services. Patients awaiting transfer for treatment comprised the majority of patient days in this category for three regions, while in Central region the majority of patients awaiting transfer were post treatment. This is not surprising, given the level of tertiary care services provided by Central region.

3.4.3 Provincially funded programs

This is the largest category of persons waiting for discharge as shown in Figure 3.4. In all regions the majority of these patients are waiting for nursing home placements, while only in Central region are there large numbers waiting for Department of Community Services facilities. The proportion of patients awaiting nursing homes is particularly large in Eastern region, representing more patient days than in the other three regions combined. One in four acute care beds in Eastern region is occupied by a patient waiting for a nursing home.

3.4.4 Patients with "Problems"

Figure 3.9 illustrates the variety of resources identified by hospital staff as being required for persons with physical or mental health problems to be discharged from the acute care setting. For patients with predominantly physical problems, hospice and higher home care limits were most frequently identified specific services, although the category "other" was frequently cited. Items in the "other" category are dealt with in greater detail in the analysis of qualitative responses.

Patients with predominantly mental health problems were felt to require supervision post discharge or community mental health services in order to be discharged.

3.5 Waiting Times

Another way to examine this is to look at the distribution of waiting times. Figure 3.7 shows how waiting times are distributed from the time of formal initiation of the discharge process to final discharge. The majority of discharges take less than a month, with generally smaller and smaller proportions at longer waits. The bars represent numbers of patients (not patient days) and the superimposed line represents the theoretical distribution[1] common to many queuing situations.

Figure 3.8 presents information on the distribution of waiting times by region determined from date the formal process started to date of discharge. Eastern region has not only longer median waits, it has higher numbers of prolonged waiting times as well. This finding is consistent with the information in Figure 3.4 which shows large numbers of persons "in queue."

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[1] This is known as the lognormal distribution and is commonly seen in studies of time spent in queues.

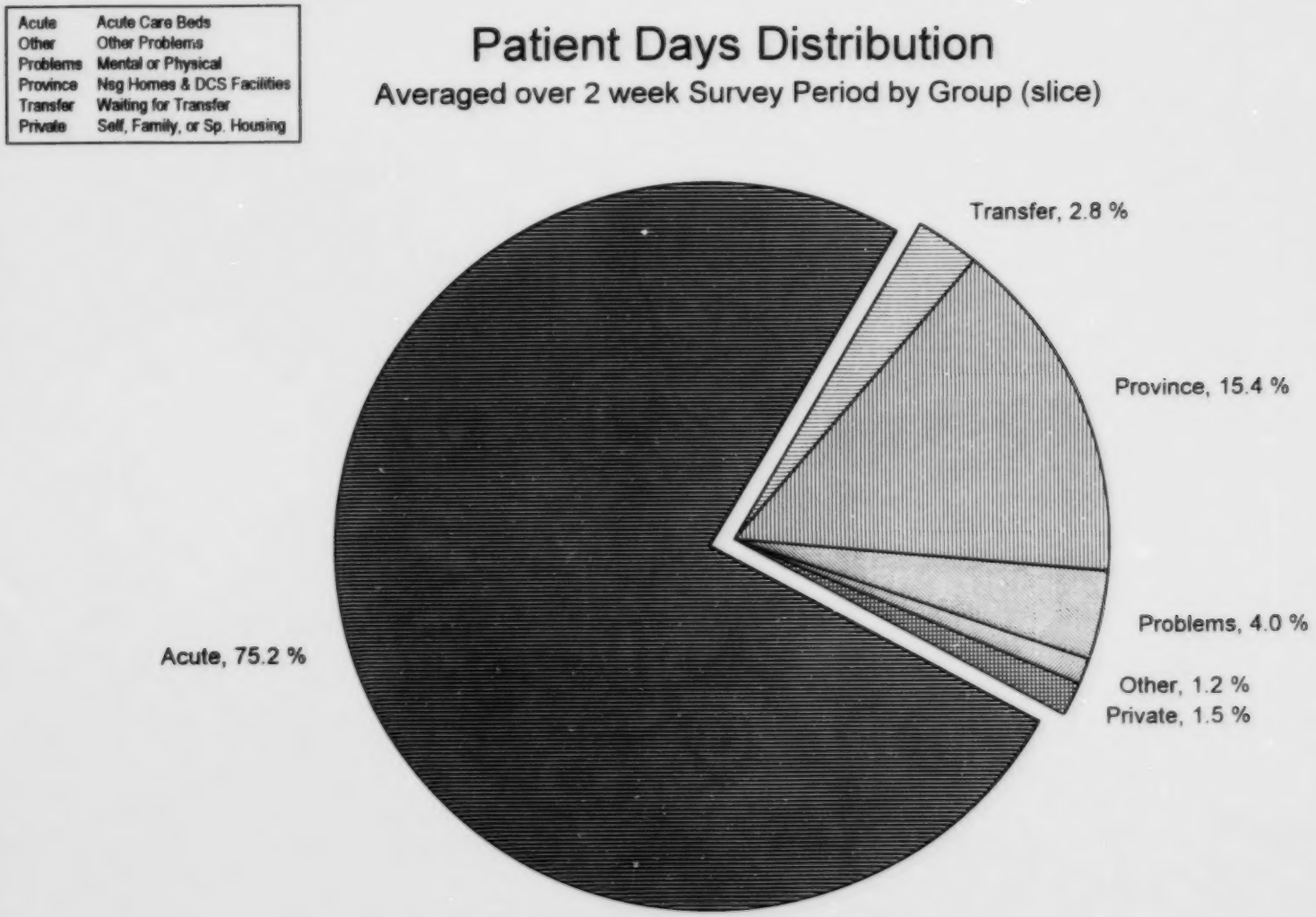

Figure 3.1 Provincial Patient Days Distribution

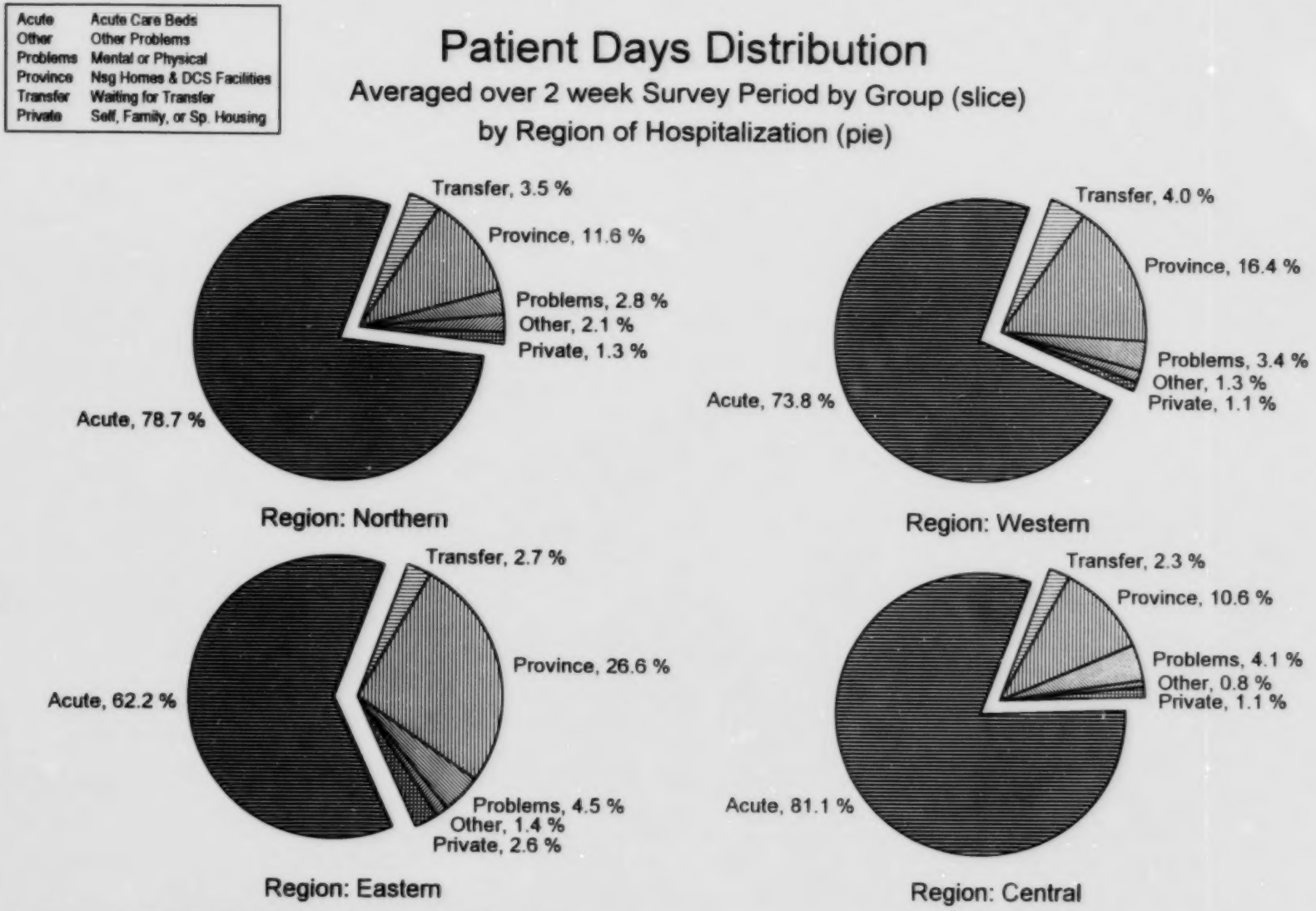

Figure 3.2 Regional Patient Days Distribution

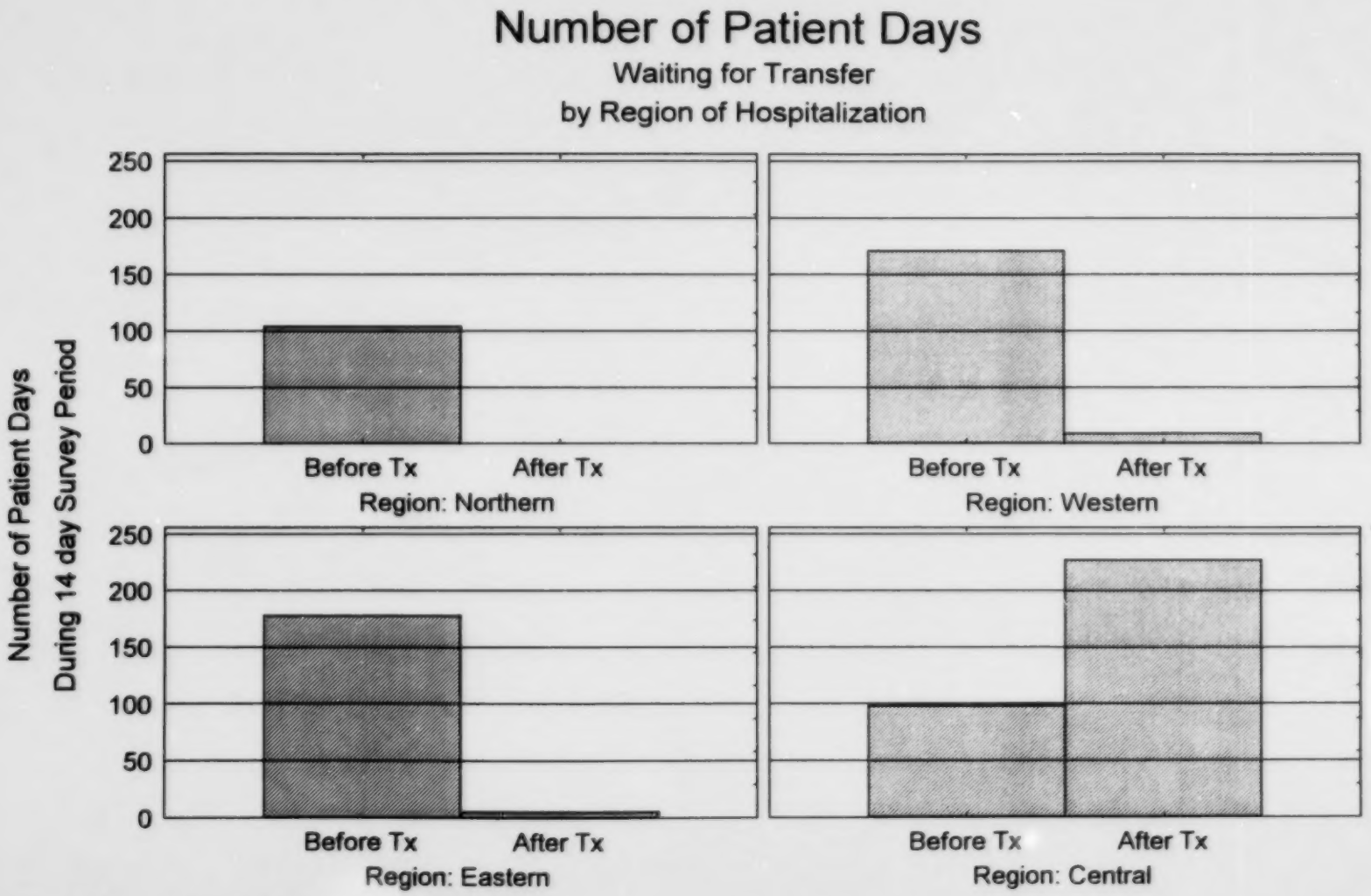

Figure 3.3 Regional Distribution of Transfers

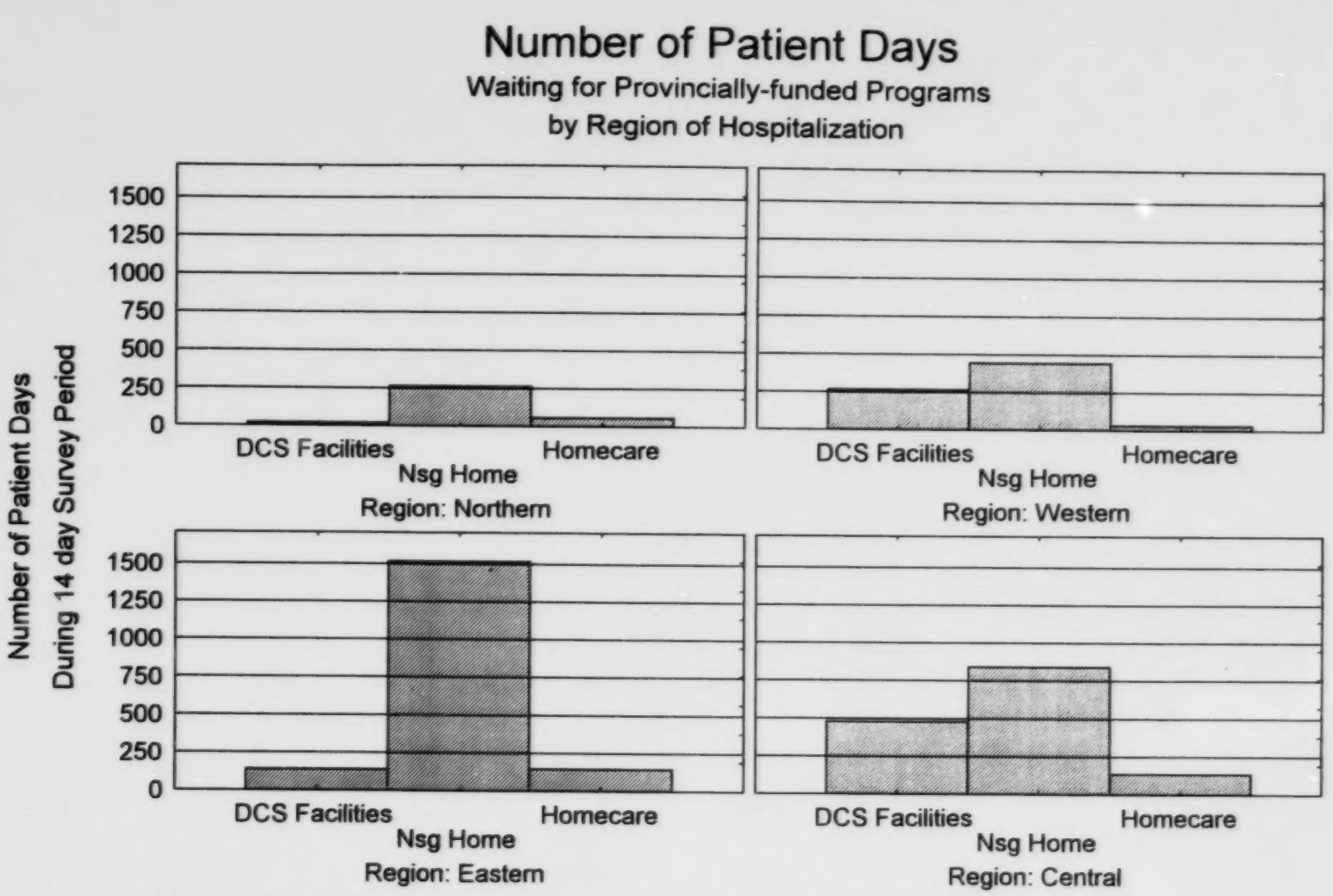

Figure 3.4 Regional Distribution of Provincially-funded Programs

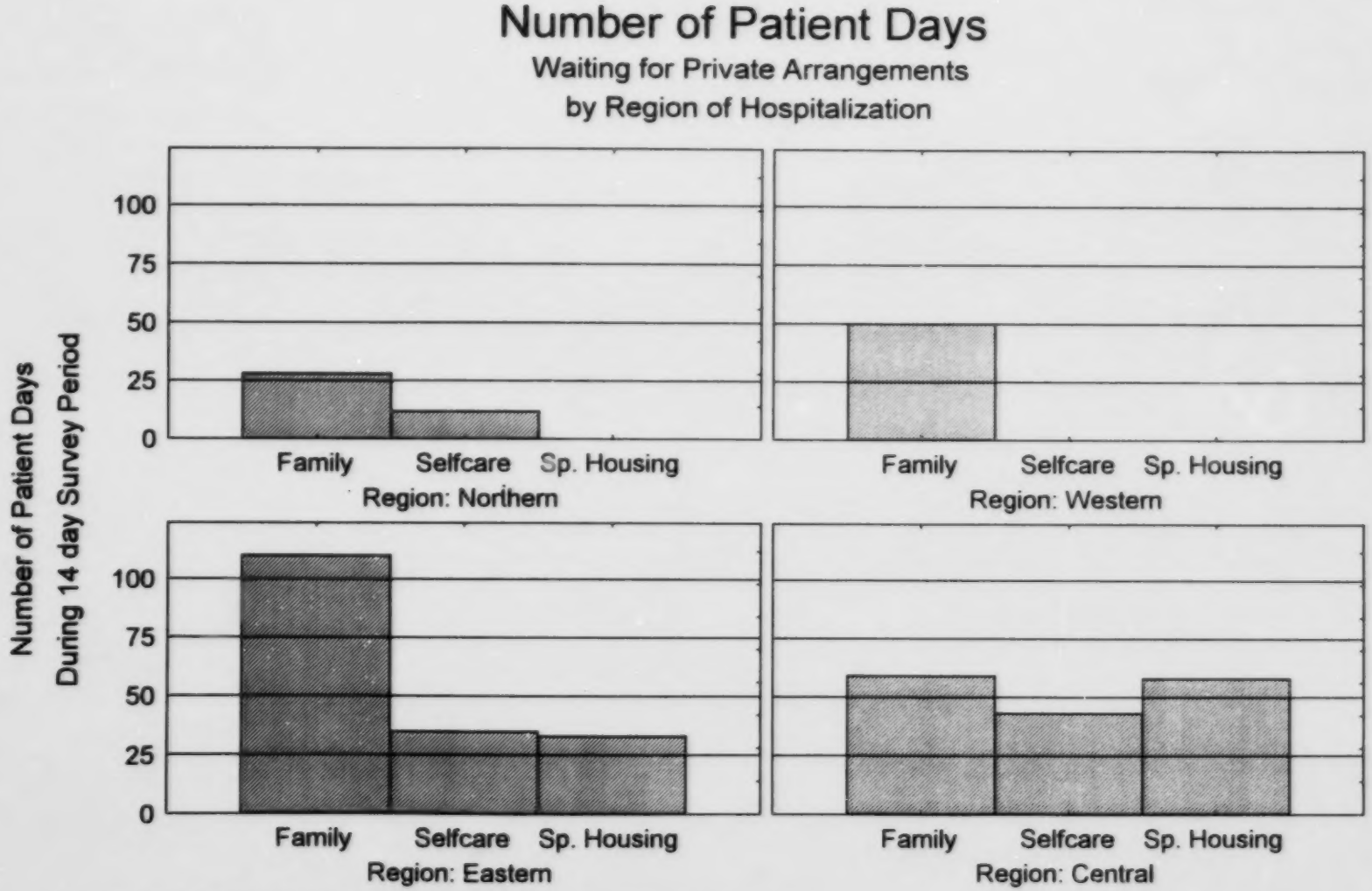

Figure 3.5 Regional Distribution of Private Arrangements

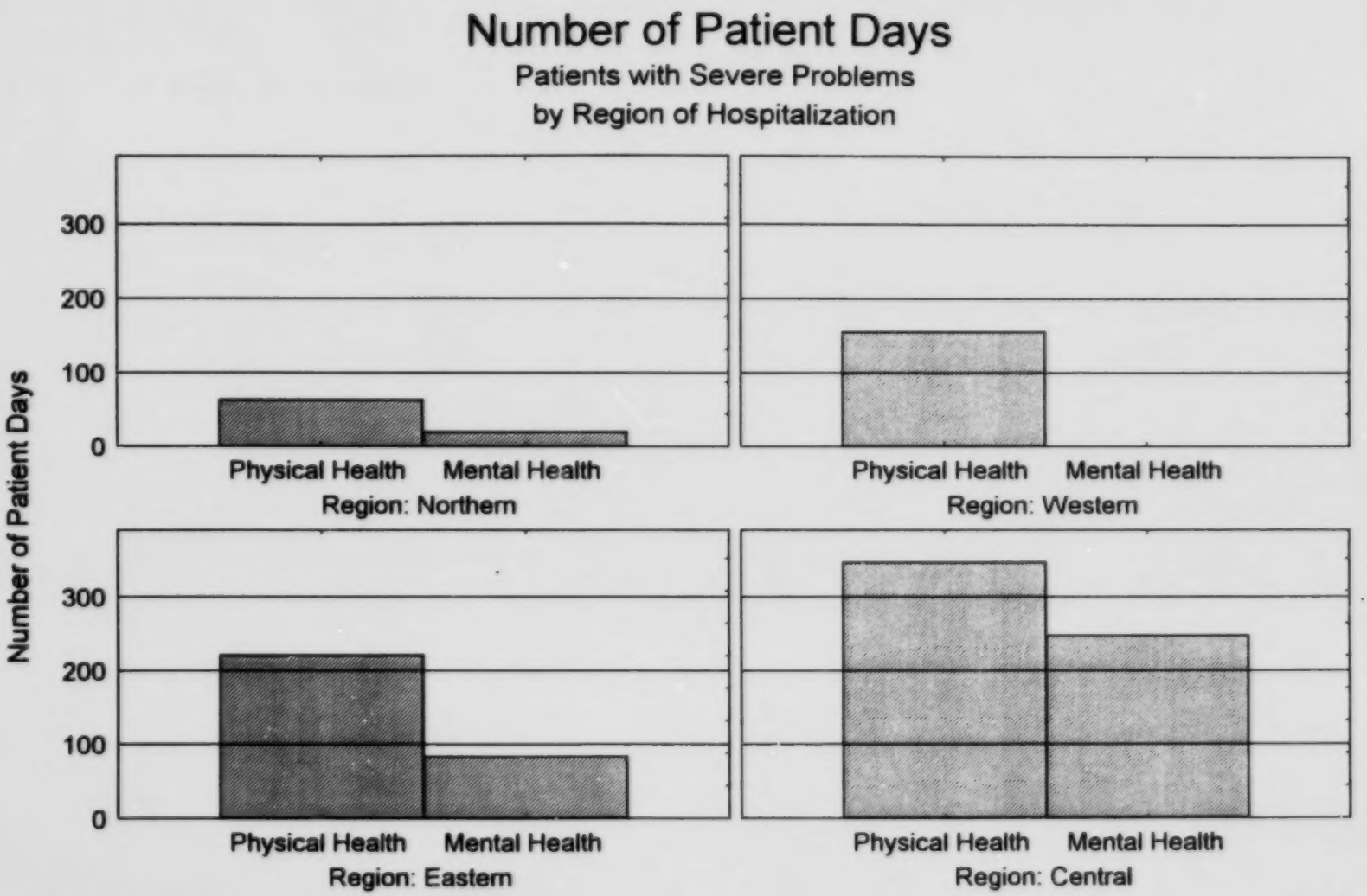

Figure 3.6 Regional Distribution of Problems

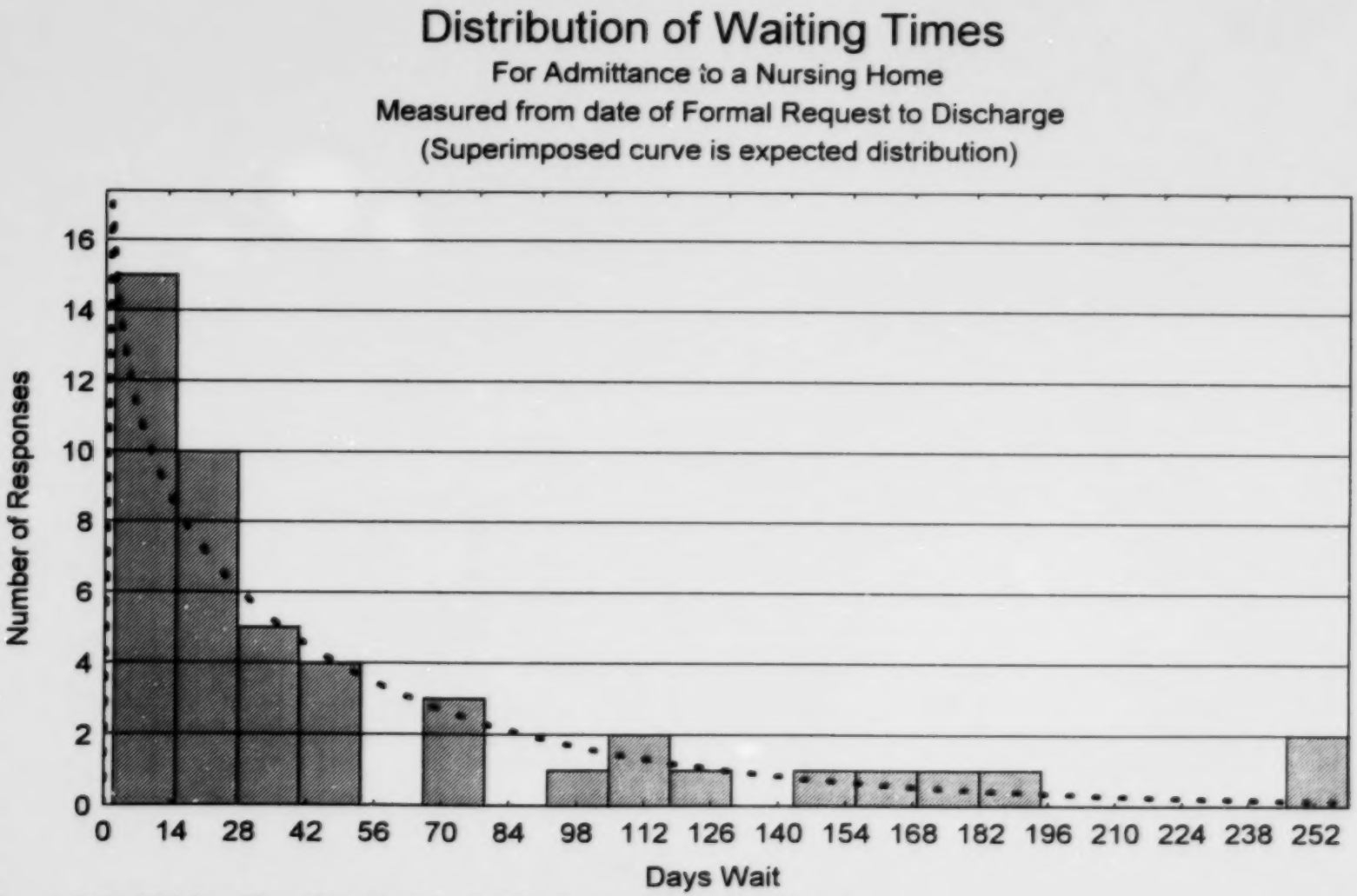

Figure 3.7 Waiting Time Distribution for Discharge to Nursing Home

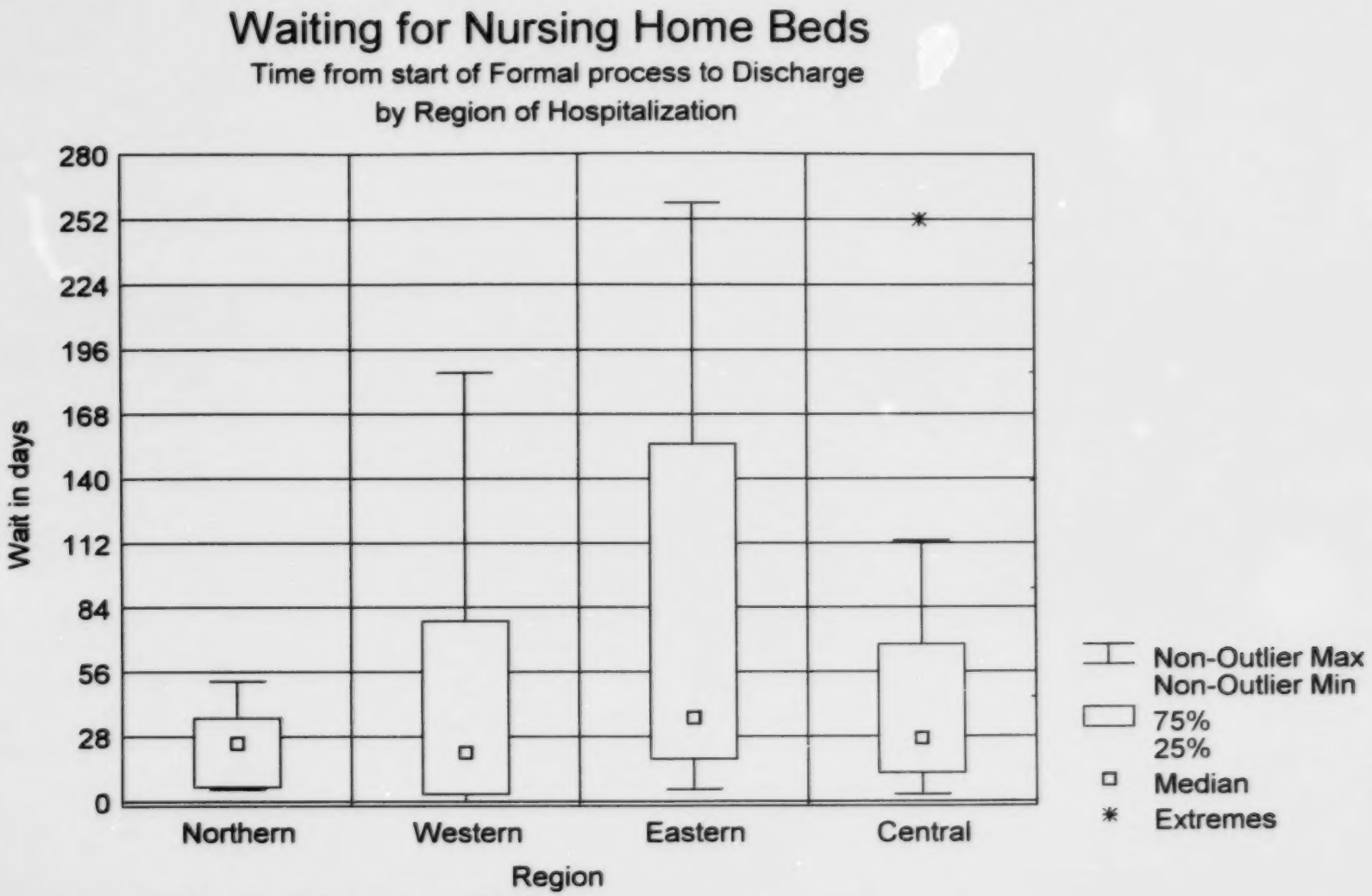

Figure 3.8 Waiting for Nursing Home Beds

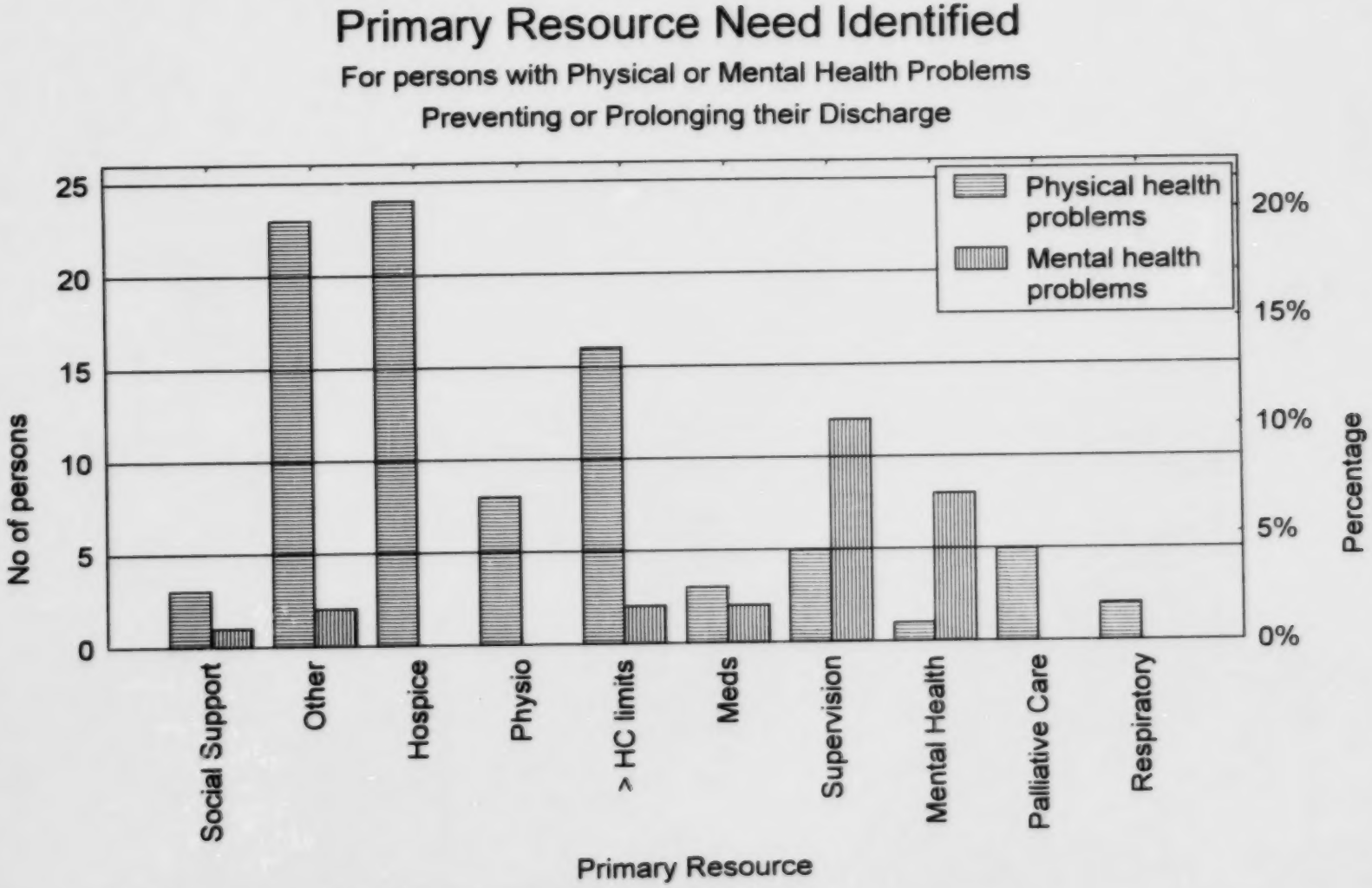

Figure 3.9 Primary Resource Required for Patients with Problems

3.6 Qualitative Results

Comments on the survey forms were abbreviated and entered into the data base. These comments were analysed as qualitative data by categorizing them under headings that best reflected the content. Not all questionnaires included comments. Therefore, one must be cautious about weighting the findings in any way. This is meant to give additional, rich information that can only be interpreted in conjunction with the quantitative analysis of the questionnaires.

There were 455 entries giving written comments concerning the Facilities Review Survey. These numbers can be subdivided as follows:

I. 50% (230 entries) were related to delays encountered when patients were waiting for Long Term Care.
II. 28% (126 entries) were related to delays encountered when patients were waiting for discharge home, or could have utilized increased Home Care or other services.
III. 22% (99 entries) were related to delays encountered when patients were being transferred to another facility.

3.6.1 Long Term Care Delays:

These 230 entries can be further divided into:

i. Nursing Home placements: 52% (120 entries)
ii. Care needs too high for current Nursing Home placement - Care needs in excess of Level II: 29% (66 entries)
iii. Other LTC (not necessarily Nursing Home placement): 19% (44 entries)

Nursing Home placements:

There were 120 entries in this category. 72 entries were related to process barriers: 30 patient/family related, 19 entries Classification-financial, 10 Classification -Community Services/DOH related.. There were 48 other, mixed comments.

Many delays are complicated by process issues. Whether or not there is a bed available, placement cannot occur because of process delays. In many cases, the hospital bed remains blocked due to processes outside the hospital's control: arranging classification meetings with Community Services for Mental health patients is a slow process; DVA arrangements are often delayed; hospital staff are not kept informed of the stage of classification - whether the hold up is no bed available or some other barrier.

Sometimes, patients are admitted to hospital in an effort to speed up the process started while the patient is in the community. Some noted that Nursing Homes are not willing to absorb costs of dressing trays, tube feeds, or special mattresses. One specific area (40% of the comments in this category) were related to delays connected with financial arrangements. If there is any dispute regarding finances, the patient remains in the acute care bed until resolution, whether this takes weeks or months. Another area of concern is that patients and families often refuse to accept placements - do not like the placement offered, feel it is too far from their community, or the patient simply refuses to return to the Nursing Home.

There were 48 other entries. Again, not every survey indicating the patient was waiting for Nursing home placement included comments. Reasons for seeking Nursing Home placement varied: requiring 24 hour supervision; living alone without social supports; increased care needs; special care needs - aggressive behaviour, dressings, adult protection services involved.

Care needs too high for current Nursing Home placement - Care needs in excess of Level II:

There were 66 entries that fell into this category.

In some cases, the patient must remain in an acute care bed as the level of care required cannot be provided in Nursing Homes at present due to staffing levels and lack of funding for special equipment, drugs and other supplies. These patients present with problems such as MRSA positive; tracheostomy; aggressive behaviour; tube feeding; ventilator dependent; oxygen (O2) required; AIDS. In some cases, the patient has been in a Nursing Home but will not be accepted back as care needs are now too high. In other cases, the patient has gone to a Nursing Home on a trial basis and is not accepted as care needs are too high.

Other LTC (not necessarily Nursing Home placement):

There were 44 entries that fell into this category.

The following are some of the required alternatives, other than Nursing Home beds, that were identified: Group Home; Small Options; appropriate locations in community to meet the needs of Mental Health patients, accommodations providing close supervision and professional clinical monitoring; affordable wheelchair accessible housing/apartment; Residential Care Facility; "attendant services" and accessible housing; Level I facility.

Mental Health patients have specific needs that are not met by current Nursing Home placements. At one institution:

i. 36 patients remained hospitalized due to "complexities associated with the discharge planning process", complex needs, physical and mental; adult protection; need for service providers; general inadequacy and limitations of community based living options; large gaps in community based support programming. Average discharge work-up is taking about 3 months.

ii. 16 patients remained hospitalized due to process delays such as orchestrating reclassification meetings when the individual is returning to the same level of care, at the same place; delays in obtaining adult protection input prior to classification; limited ability to exercise client choice in placement; general inadequacy of community based living options.

iii. 13 patients remained hospitalized due to having dual disorders, developmental delay and coexisting mental illness. Continuing care needs are high, many are classified for D3 levels of care, which is not available. These are similar to needs of some RRC residents seeking community placements.

3.6.2 Delays to Home Discharge, need for increased Home Care or other services:

The 126 entries can be further divided into:

i. Delays to Home Discharge-42% (53 entries)
ii. Home Care- 25% (32 entries)
iii. Palliative- 24% (30 entries)
iv. Respite-9% (11 entries)

Delays to Home Discharge

These patients were waiting to return to their own homes in the community. 16 entries cited delays as the home required modifications; special equipment was required; family members had to come from a distance to offer assistance or arrange for private caregivers. 15 entries cited patient or family refusal to leave hospital and return home even though the hospital had recognized they no longer required acute care services. In six cases, the caregiver had become ill or was not available to care for the patient at home. Three could not leave hospital as they could not afford to purchase required medication.

Home Care

There were 32 entries that fell into this category.

Few comments concerned delays in service. Many remarks concerned the need for higher HC limits, the needs exceeded what can now be offered by Home Care Nova Scotia. Some examples were: simple pneumonia; oral antibiotics; IV heparin; IV

antibiotics; dressings for ulcers. It was felt these should be able to be offered at home. Other reasons patients were kept in hospital were: delay in setting up Home O2; patient would have to pay for O2 at home; no HC on native reserve; no support in community for CAPD; need for physiotherapy and occupational therapy.

Palliative

There were 30 entries that fell into this category.

Family felt unable to provide care at home: split shift was required; family unable to cope with increased care requirements or fear of the dying process. Some who were in a hospital acute care Palliative Care Unit were now stabilized and ready to leave the Unit, but the higher Home Care limits and support were not available. Others would benefit from a long term hospice care facility.

Respite

There were 11 entries that fell into this category.

In many cases, respite is needed as caregivers are under considerable strain and need time out in order to cope. There is often a need for social supports.

3.6.3 Transfer Delays:

The 99 entries related to delays encountered when patients were being transferred to another facility can be further divided into:

i. No bed available/accepting facility short staffed- 34% (33 entries)
ii. Wait for Cardiac Services-28% (28 entries)
iii. Wait for Rehabilitation-25% (25 entries)
iv. Wait for restorative care- 10% (10 entries)
v. Patient/family refused transfer/Delay in discharge planning 3% (3 entries)

No bed available/accepting facility short staffed/wait for bed:

There were 33 entries that fell into this category.

Comments included: delay as accepting hospital short staffed; no bed available at accepting hospital (Regional Hospital/ home hospital/tertiary care hospital); wait for specialized tests/services (cancer, Rheumatology, etc).

Wait for Cardiac Services:

There were 28 entries that fell into this category.

Cardiac Catheterization, cardiac services/investigation, bypass Surgery, angiogram and open heart surgery were identified.

Wait for Rehab:

There were 25 entries that fell into this category, waiting for admission to a rehabilitation facility. In some cases, it was felt the patient could have waited at home with supervision, social supports, and availability of physio and occupational therapy.

Wait for restorative care:

There were 10 entries that fell into this category.

Patient/family refused transfer:

There were 3 entries that fell into this category. One entry identified delay in discharge planning as holding up the acute care bed.

The full comments are listed in Appendix 1

Chapter 4
Discussion

4.1 Limitations of the study:

4.1.1 Scope

This review did not address all the aspects of patients occupying an acute care bed when they could have been cared for more appropriately in another setting. This study looked at the barriers to transition - what delays or barriers prevented timely discharge from acute care? Other issues such as inappropriate admission were not specifically considered.

In planning this review, the Team was aware that utilization management reporting in a format that allowed comparison was non-existent in the province. There was no one standardized tool in use that all hospital administrators, physicians, nurses or discharge planners were familiar with and using on a regular basis. Therefore, it is acknowledged that the results are affected by a learning curve. It has been shown that when institutions first employ utilization management techniques and tools, there tends to be under reporting at first while the participants learn to recognize the nuances of the new system. Many of the participants in this study were not familiar with utilization review tools and techniques.

4.1.2 Use of a new survey instrument

In order to have a consistent reporting tool for use province-wide, the Team developed a new survey instrument. Although care was taken to have input from the stakeholders and to have a short pilot test completed prior to dissemination throughout the system, it is recognized that this tool has not been through as rigorous testing as the commercially developed Utilization Management Tools available on the market. To employ such tools would have been extremely time consuming and resource intensive.

4.1.3 Temporal considerations

This review was conducted over a four week period in November and early December. Each facility tracked their patient activity for two weeks. This is a very short time frame and may be subject to seasonal factors. Although the findings are consistent with other studies, one cannot conclude that the specific activity in the two week period can be generalized to a full year of operation. By comparing survey results to other information available, it is felt that this survey can at least be considered a minimum reflection of the issues involved.

4.2 Combining Quantitative and Qualitative information

The inclusion of space for open-ended responses allowed, in some cases, very detailed information, or responses that lay outside the range of hard-coded options available. Not only did these qualitative responses assist in recoding the large numbers of "other" responses, they provide additional depth to many of the quantitative responses.

4.2.1 Transfers

Transfer problems averaged 2.8% of patient days during the study period, and were, with the exception of Central region, predominantly patients awaiting treatment. While there was no survey question asking what treatment service(s) the patients were waiting for, frequently type of service required was indicated in the respondent's comments. The commonest treatment resource for which patients were waiting was cardiac (*e.g.* angiography or other diagnostic services, or surgery), followed by rehabilitation services. Frequently there was an indication in the notes that the accepting facility was either short staffed or had no bed available.

4.2.2 Long Term Care

The process of discharge to a nursing home or a Department of Community Services funded facility is complex and delays may occur at any of the stages from the patient being ready for discharge through to the actual discharge itself. Particular note was made of the difficulties surrounding discharge planning for patients with mental health problems. Respondents indicated the need to schedule meetings with Community Services for classification and that this could be a slow process. One region indicated that Community Services staff were only available on certain days.

In addition to the comments recorded in the survey questionnaires, the survey researchers were frequently informed of the communication gap between the classification process and the patient's hospital. Many times a hospital would not know

the classification status of a patient awaiting discharge to long term care. This has a potential consequence in determining the stages of the discharge process since the exact classification date may not be known leading to a mis-specification between the "assessed" and "classified" stages. This does not, however, affect the measure of the time from formal initiation of the discharge process to discharge.

4.2.3 Home Care

While waiting for home care was not an issue either quantitatively or qualitatively, patients classified as having "problems" frequently had comments that they required access to expanded home care services that would include IVs, wound care, or home oxygen; or specialized services such as physio or occupational therapy.

The lack of palliative or respite services was frequently identified as not only a barrier to discharge, but often the underlying reason for admission. While the survey purpose was not to judge the appropriateness of admissions, in this case a number of admissions could have been diverted to community care had the necessary services been available.

4.3 Conclusions and Observations

The limitations of this study have already been discussed, and the following conclusions and observations must be considered in light of those limitations.

4.3.1 Waiting for Nursing Homes

Nursing Homes were by far the most common resource required by patients waiting greater than 24 hours for discharge, measured both by frequency of occurrence and total inpatient days. The discharge process can be complex, with multiple steps and dependencies involved. There are issues of cooperation, *e.g.*, the attending physician must complete the necessary documentation to initiate the process, the patient and/or family must provide detailed financial information, and hospital and assessment staff must make time available to meet to discuss the more complex cases.

Clearly, this is a process where many things can go wrong, and respondents provided numerous examples of how delays can be introduced in each of the stages. It is important to distinguish between process delays arising during the discharge stages and the final waiting period for a nursing home bed following classification. Waiting following classification arises because of a mismatch between the apparent need for nursing home services and the available supply of appropriate beds.

In the case of Eastern region, there is a clear mismatch between the demand for nursing home beds and their availability. It is beyond the scope of this study to determine if the mismatch arises on the demand side due to differing levels of illness or disability, lack of alternatives to nursing home placements, or preference for nursing homes as an option; or if there is an insufficient supply or distribution of nursing home beds in Eastern region relative to the numbers of elderly in the population. However, these issues must be examined, since the high proportion of patient days waiting for nursing home placements coupled with the high census counts in Eastern region indicates this problem has a major impact on their acute care services.

4.3.2 Home Care

Home Care as it is currently provided in Nova Scotia does not include a number of advanced nursing practices, nor will it provide services for patients whose combined intensity and duration of services exceed a defined cutoff. Survey respondents repeatedly noted that changes to these various Home Care limits would be required to allow some of their patients to return home, or could have prevented an admission in the first place. This observation was especially common for patients having medical conditions that could be characterized as requiring respite or palliative care.

It is important to recognize that respondents suggesting higher Home Care limits may not fully appreciate the additional complexities, potential risks, and escalation in costs involved in introducing advanced nursing practice techniques and high frequencies or intensities of care into the Home Care system. There are implications for the medical practitioners involved in the care of patients with complex, high intensity needs being treated within the Home Care Program. Despite these cautionary points, respondents are entirely correct in suggesting that, lacking such an alternative, admission to an acute care facility remains the only available option for many of these patients.

4.3.3 Chronic care

Patients in Nova Scotia with chronic stable physical or mental health problems requiring a high level of care are currently cared for in acute care hospitals, or, through special arrangements and funding, in certain long term care facilities. Specialized chronic/ heavy care programming would be capable of handling a portion of the current population of patients in this category. Such a move might allow staffing and programs more appropriate to the needs of the chronic care population while freeing the acute care hospitals to concentrate on patients requiring active investigation and treatment.

4.3.4 Mental health

The special needs of persons with mental health problems cut across a number of the resource areas addressed in this survey. There are issues related to the group who remain chronically hospitalized that may be addressed through some form of chronic care option. For those who can be discharged, community resources in the form of supervision, special housing, or community mental health services were frequently cited as being necessary for discharge. While special housing was often indicated as a requirement by patients in Central region, this option was not often identified in the other regions. It is easier, however, to arrange such resources in an urban setting where there is a greater concentration of services. The more rural areas of the province may require or utilize different options to meet the needs of persons with mental health problems.

4.4 Summary

The Facilities Review Survey was a limited attempt to determine the state of the Acute Care facilities at a particular point in time. Since the sampling was done during a single 4 week period, insufficient information is available to extrapolate with confidence to a full year. To do so would require repeated samples during all seasons, and of sufficient duration to provide reasonable numbers from the smaller facilities. Despite these caveats, the overall results of the survey confirmed general impressions held by persons working in, or familiar with, the acute care sector. Thus, the survey was able to quantify many of the assumptions held at the beginning of the survey about the distribution of patients waiting for various resources, and differences between regions.

Despite the stated limitations of the survey, there is no real need to carry out an expanded version within the foreseeable future. Although this would refine our estimates of the numbers of persons waiting for various resources while in acute care facilities, the process would merely provide further confirmation of where the problems exist. Such confirmation would not add to our knowledge of how to provide the resources required to reduce the numbers of patients waiting. The next steps must be in examining issues such as the availability of Long Term Care, *e.g.,* whether the long waiting times are an issue of insufficient capacity, inappropriate placement, failure to consider alternatives, *etc.* The needs of the chronic care and mental health patient populations require special consideration. Finally, appropriateness of admission will continue to be a highly relevant issue since interception of some of these patients, especially those requiring respite or palliative care, may not only prevent an admission, but be more appropriate for the patients themselves.

Chapter 5
Recommendations

1. Frequent delays occur in transferring patients between hospitals and there seems to be no mechanism that would allow more efficient transfer.

Recommendation: Investigate methods to allow more efficient transfer of patients between acute care facilities.

2. The process for classification and acceptance into Nursing homes is complicated and lengthy. Many delays were identified due to process issues.

Recommendation: Establish a working group to address the process issues and streamline the classification and admission process.

3. The current system does not provide care for clients with high care needs. As a result, many of these patients remain in acute care beds for an indefinite period.

Recommendation: Convene a working group to look at location of beds, staffing and access provisions required to establish designated Chronic Care Units/Hospitals for patients with care needs exceeding Level II.

4. Frequent calls for higher home care limits require an examination of current home care policies and implications of accepting patients with higher care needs.

Recommendation: Investigate the feasibility of an expanded role for Home Care, both in terms of intensity and duration of care.

5. Many patients, especially Mental Health patients, remain in acute care beds because there are no community facilities to meet their needs. These patients do not require current Nursing Home services, but do have specialized needs.

Recommendation: The Departments of Health and Community Services should cooperate on initiatives that address the specialized housing needs of these patient populations.

Appendices

Appendix 1 Detailed Qualitative Results
Appendix 2 Survey Instrument
Appendix 3 Instruction booklet
Appendix 4 Census forms

APPENDIX 1 Detailed Qualitative Results

Total entries, 455.

I. Waiting Long Term Care. 50% (230 entries)

1. Nursing Home placements: 120 entries (A. 72 process delay; B. 48 entries general)
2. Care needs too high for current Nursing Home placement - Care needs in excess of Level II: 66 entries
3. Other LTC (not necessarily Nursing Home placement): 44 entries

II. Home Discharge, Home Care, Palliative, Respite: 28% (126 entries)

1. Delays to Home Discharge-53entries
2. Home Care Related-32 entries
3. Palliative-30 entries
4. Respite-11 entries

III. Delay awaiting transfer to another facility: 22% (99 entries)

1. No bed available/accepting facility short staffed/wait for bed: 33 entries
2. Wait for Cardiac Services: 28 entries
3. Wait for Rehab: 25 entries
4. Wait for restorative care: 10 entries
5. Other: 3 entries

I. Waiting Long Term Care. 230 entries

1. Nursing Home placements: 120 (72 specifically process delays; 48 entries general)

A. Process Delay in arranging Long Term Care: 72 entries; 30 patient/family related, 19 entries Classification-financial, 10 Classification -Community Services/DOH related.

a. patient/family related (30)

- delay, family reluctant to make decision
- delay in classification , family emotional stress, non-compliant
- follow-up meeting with husband-now willing to complete process
- family hasn't decided on NH placement
- delay in meeting with family
- family delays in completing classification process (2)
- difficult to place- young, family interferes
- pt. withdrew name from placement list; daughter not prepared to take her home
- wife refused a bed based on location-will not be allowed to refuse another

- pt. refused placement, 30 minute drive out of town
- refused placement, requires 24 hour care, wants to go home
- pt refused NH, adult protection cannot intercede in hospital; awaiting renovations to home.
- patient/family refused placement (9)
- refused [redacted][2] placement, wanted to return to [redacted] - needs extra care
- family in conflict: son says yes, husband says no to placement. Pt. will go if husband can go at same time.(accepted Nov 26)
- pt refused [redacted] X2, being billed for acc?
- pt. refused to go back to NH
- pt. refused- not in her community (3)
- family declined a bed

b. Classification-financial (19)

- Barriers to classification process - 8+ months, refused for placement due to financial issues. DOH and Community Services involved, cannot decide "who's decision it is".
- CS worker and husband have not been able to get together to complete process (>1month)
- Bottlenecks: 1. SS personnel work part time [redacted],often causes delay up to a week. 2. Getting in touch with family to do financial forms
- family slow to return forms to CSA
- family have not completed financial papers.(2)
- form B not received from son
- son has not provided CS with financial records
- SS having difficulty contacting son who has power of attorney; NH bed not available
- financial component not worked out with family. DOH will not classify till funding issues resolved.
- financial information missing; life insurance policy needs to be signed over to DOH, son says he is not beneficiary and has no control over signing it over); son has made withdrawals from fathers pension; "In the interim, [redacted] is homeless and there does not appear to be anyone (DOH or the hospital) doing anything to resolve these issues".
- "refused for NH placement; CS assessment indicated she had the required amount of income/assets to be a private pay resident in a nursing home."CS determined that the daughter spent a great deal of her mothers savings. Difficult to place as well as she has a g-tube.
- "DOH became aware of the existence of a secondary property owned by pt." unless the property signed over to them, will not fund a bed. Family not cooperating.
- family refused consistently to contact SS to complete financial papers

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[2] Please note: Where names of persons or facilities or other identifiable details occurred in the transcripts, the information has been blanked out to preserve confidentiality.

- financial issues; son has some of her money?
- husband will not cooperate with the financial assessment
- does not have all the financial info; couple requires assistance from SS re division of assetts
- ex-wife would not complete financial papers
- classified, but CSA will not pay for NH re "missing money"

c. Classification -Community Services/DOH(10)

- delay in meeting with Community Services (NS Hosp requires meet in person) (2)
- delay in setting up formal classification meeting (MH)
- not kept informed of status of classification
- "Have not heard from Community Services"
- waiting feedback re classification from DOH
- waiting classification/ status unknown (2)
- LTC pt, reclassification needed prior to transfer back
- Could not contact SS for 2 weeks. No bed available

d. Other (13 entries)

- NH has no funding for dressing trays
- post CVA, 24 hour care. No family. Long delays while CSA established guardianship (Public Trustee). Difficult to place her : g-tube. [redacted] willing to accept since July 1999 if DOH will cover cost of tube feed and special mattress.
- awaiting paperwork-physician (housestaff) hasn't completed
- NB social worker to arrange NH
- doesn't have landed immigrant status
- NH unable to readmit due to decreased staff and no physician available, 4 day delay
- waiting for DVA (2)
- delay checking eligibility for [redacted]
- assessed by DVA who states "not his job to call around and find a place".
- hospitalized in an effort to speed up process
- waiting at home for LTC, admitted due to caregiver breakdown
- delay due to staff shortage in NH

B. General : 48 entries.

- requires 24 hour supervision, support; severe respiratory status
- lives alone, requires 24 hour care
- attendant care needed but pt. can't afford it
- lack of social supports
- waiting to see if insurance will cover 24 hour nursing and equipment needs
- waiting NH; could have remained home with higher HC, supervision, social; supports, pt/ot. COPD & depression
- classified as level I; to be reclassified.

- family not willing to take pt. home due to increased needs
- mother not coping at home; NH to be explored
- admitted with DVT, # hip. Caregiver /provider breakdown. Unable to return to prior arrangements. Wait for LTC
- needs higher HC, supervision, social supports, or to NH
- was in [redacted] as private pay level I. Won't take him back until transferred to portable O2; now level II
- waiting for NH; could go to a Hospice
- pt. had been palliative but progressed well and will be for (NH) placement. Family has not come to terms with this yet.
- started process for NH; still waiting for Rehab post amputation
- had been placed in a boarding home but readmitted as too great a care. Waiting for NH
- Failure of previous care arrangement, family to arrange another boarding facility until pt can be placed in LTC.
- came in from ARC program at Scotia; there 15 years; schizophrenia; seeking new placement
- Transferred from [redacted], waiting NH
- care required too low for NH; awaiting reclassification
- requires 24 hr supervision, assistance with walking. Did not wish to go to NH but agreed to start the process.
- (patient) refused placement, requires 24 hour care, wants to go home
- aggressive behavior
- recently refused as not appropriate for available roommate - pt confused, rambles
- heavy level II, leg dressings
- delay in returning to independent care at [redacted]; increased support from HCNS
- chronic neurologic illness requiring pain control, monitoring. Social issues.
- dementia, Parkinson's, chronic depression, CVA
- delayed by complexity of discharge process(MH) (11)
- requires maintenance ECT; delayed by complexity of discharge process(MH)
- Adult protection involved; " "Treatment Team believes discharge process should proceed, and delays are negatively affecting stability". Social Services deferred classification.(MH)
- admitted by adult protection ; placement process to begin (4)
- Adult protection involved; waiting placement. Declared incompetent (2)
- declared incompetent. Private pay

2. Care needs too high for current Nursing Home placement - Care needs in excess of Level II, 66 entries

- high care levels; MRSA positive; tracheostomy
- trach, immobile (2)

- "not eligible for NH placement because she has a tracheostomy and discharge options are limited to Twin Oaks Hospital".
- no level 3 facility, must stay in acute care bed
- delay in CS meeting with family to complete application. Gastric tube feed, full support care.
- care is high, some NH reluctant. Some won't accept. Pt angry she must use her RRSPs to pay NH costs (49 yrs old). Needs 24 hour care.
- classification denied; positive culture stool
- MSRA , requires private room
- "level III nursing care required", trach, MRSA positive, j-tube.
- level III, nutritional status (2)
- pt initially refused, now increased level of care due to nutritional status.-levelIII
- level III DVA
- classified type 3, NG tube
- level of care too high; progressive motor neuron disease, trach, insulin, 24 hour tube feeding.
- no nursing home will accept, care needs too high. Has g-tube, requires deep suctioning
- denied (admission to NH), care required too high (2)
- pt trached and ventilator dependent; kyphoscoliosis. Remains in ICU as no facility available or money for in home support.
- depression, dementia; trialed at a NH but they could not meet her care needs; [redacted] the only option, [redacted] no longer accepting new pts.(MH)
- end stage renal disease, CAPD-NH won't accept
- came from NH; now care level too high (4)
- high level care / ulcer (2)
- waiting since August(3 months); bed became available but tested positive for c-diff.
- came from NH; MRSA, dialysis, needs private room; not classifiable
- pt needs continuous O2
- readmission to NH with O2 concentrator and 24 hour private care
- heavy level II, peg-tube/g-tube, NH options very limited (3)
- Quadriplegic, NG tube
- admitted from NH; refused to take back, care needs too high (2)
- ventilator pt; waiting over a year (4)
- Pt has never been offered a NH bed, g-tube.
- refused (to accept) patient due to increased level of care, tube feeding, total care
- assessed as level III; g-tube (2)
- waiting over a year; g-tube recently removed
- Has AIDS, only one NH will accept him and he is waiting a private room. Discharge options very limited.
- pt. refused placement at NH; next NH refused patient because he smoked in bed.
- Pt. has Multiple Sclerosis. Was in NH till they discovered he uses marajuana to control MS symptoms. Presently not classifiable.

- trach, speech, mobility, aggressive
- transferred from NS Hospital; no placement facility will accept
- has to change to another HSC with increased support
- requires a facility to deal with his manipulative behaviour, set limits
- refused level II, aggressive behaviour (2)
- Home for special care refuses to take pt. back - behavioural (5)
- "Reqiures augmented Level II Nursing Home type placement"; behaviour management (2)
- "Requires dedicated setting with adequate supervision to deal with potential management concerns, no available placement willing to accept "- behavioural (2)
- Increased care required; cognitive impairment, aggression. No facility will accept

3. Other LTC (not necessarily Nursing Home placement): 44 entries

- wait for Group Home bed; delayed by complexity of discharge process(MH)
- Group Home not available
- was classified as level I by DVA so wouldn't fund NH bed. Awaiting reclassification
- wait for suitable facility; delayed by complexity of discharge process(MH)
- being transferred to adult system, Mental Health
- no appropriate location in community; needs close supervision; aggressive behaviour - MH, needs professional clinical monitoring (7)
- needs supportive housing, previous suicide attempts (MH)
- delay while finding accommodations- social work assisting. Lacks social supports
- admitted from supervised home; no active treatment; physician has not discharged.
- requires small option
- staffing problems at small options home. Difficult to find appropriate small options due to needs and wants.
- hold hospital bed to assess if placement OK.
- level I, private pay
- for level I facility (2)
- care too low for NH, ok for ARC but refused to leave community
- adequate housing being sought to allow him to live on his own
- senior citizens apartment required
- lengthy wait list for Community Support for Adults
- wait for Residential Care Facility
- waiting for wife to find wheelchair accessible apartment (2).
- needs affordable wheelchair accessible housing
- difficult to find appropriate accommodations- was on a pass but returned as environment could not meet his needs; needs single room, quiet environment, staff supervision; chronic psychiatric needs
- wait assessment by housing authority
- RRC required

- waiting for NH, would prefer home, requires "attendant services" and accessible housing
- for other LTC, Community supports for adults (MH) (3)
- adult protection investigation, injuries in group home
- delay returning to Adult Residential facility- unable to take anyone on the week-end, skeleton staff
- waiting for NH, condition improved and placed in small option
- "Many social and lifestyle problems-non-compliant with medication"; adult protective services involved.
- close supervision for compliance with meds needed-complex
- needs supervision; drinking during HC visits; alcohol dependency
- 36 surveys of MH patients, "complexities associated with the discharge planning process", complex needs, physical & mental; adult protection; need for service providers; general inadequacy and limitations of community based living options; large gaps in community based support programming. Average discharge work-up takes about 3 months.
- 16 MH surveys- process delays orchestrating reclassification meetings when the individual is returning to the same level of care, at the same place; delays in obtaining adult protection input prior to classification; limited ability to exercise client choice in placement; general inadequacy of community based living options.
- 13 surveys, MH. People with dual disorders, developmental delay and coexisting mental illness. Continuing care needs high, many classified for D3 levels of care. Similar to needs of some RRC residents seeking community placements.

II. Home Discharge, Home Care, Palliative, Respite: 126 entries

1. Delays to Home Discharge-53
2. Home Care-32
3. Palliative-30
4. Respite-11

1. Delays to Home discharge-53 entries (16 entries related to making arrangements at home; 15 entries due to patient/family refusal; 9 entries re physician delay; 6 entries caregiver related; 7 other)

A. Home arrangements(16 entries)
- building home to accommodate care needs of child
- need modifications to home (3)
- family to make arrangements, special equip (2)
- "Family delay" 9 days
- Family out of country, pt. waiting for their return; refused other assisatance
- waiting for family to arrive from BC to give care

- waited extra day for daughter to return home
- family member away 2 weeks; other family members would not make decision re disch. Plans
- waiting for family to get ready
- family need to arrange caregivers and family schedule
- 2 day delay while family made private care arrangements
- family needs to arrange private care givers (2)

B. Patient/family refusal(15 enties)

- refused HC or help (5 days)
- family doesn't want to pursue disch until 2nd opinion from Rehab
- pt ready for pschyosocial rehab but refused.
- family refuses to take patient home
- physician kept pt. as family unwilling to take her home, didn't feel they were ready
- Care provider refused to provide care. Wife refused HCNS, refused to follow recommendations by Physio/OT
- requires home O2, refuses to accept it
- admitted with suspected # hip, x-ray OK. Family upset & refused to take her home. GP left her in hospital 4 fdays, "Pt. Needed time ".
- elderly relatives unable to care for client; client refuses to hire private caregivers, says wife and sister-in-law will assist
- family refuse to take pt. until mobility/cognition improves
- client informed physician she was not ready (10 day delay)
- pt refused to go home with increased supports
- could go home with HC but family refuses until she is completely healed; VON could do her dressings, Physician refused to d/c
- wife very stressed, refused to assist with injections etc. Delayed disch while husband taught to give self care.
- O2 arranged for Friday- wife took phone off hook, didn't want him home that day. Arranged for Monday

C. Physician delay(9 enties)

- wait for gastroscope
- disch not written/ physician delay (5)
- could have had tests as OP and managed pain at home. Admitted Fri, tests Mon
- could have had bronch as OP (had it Fri, surgery not until Mon)
- out on day pass; physician preferred hospitalization; for observation of JP drain

D. Caregiver related (6 entries)

- mother hospitalized; child requires 24 hour care therefore also hospitalized
- stayed in hospital to be with wife/translate for her. Both were patients initially (car accident).

- pt. requested admission post op (day Sx) because he had no one to stay with him at home
- social admission, transfer from [redacted]; husband was caregiver, now palliative.
- 3 day delay, husband ill.
- care giver had emergency surgery; pt admitted until alternate arrangements made

E. Other (7 enties)
- delay 15 days, emotional upset, inability to cope, needed MH services
- delay, family had no phone/car; waiting for them to visit
- family dynamics prevented a safe d/c prior to completion of chemo therapy
- pt is here awaiting wound healing following surgery in Halifax. Because of home environment, is refusing HCNS- I doubt that HCNS would provide service to this home.
- required financial coverage for drugs (2)
- Pt. can't afford CPAP , no drug plan

2 .Home Care Related-32
- required increased HC services
- awaiting vendor for setting up Home O2 is a regular occurrence. Vital Aire respiratory therapist has indicated there are 2 days a week to come to [redacted] to set up Oxygen, therefore not unusual to experience delay in discharge . Vital Aire ReResp Therapist must assess pt. response to the concentrator- if sites had a concentrator to trial patients with this mode of O2 delivery, the discharge process could happen more efficiently.
- No HC on native reserve; no support in community for CAPD
- family reluctant to have HC, prefer pt. in hospital until well
- family to arrange increased HC
- physio/OT (10)
- higher HC, physio, help with ADL
- HC not available - new service
- admitted for IV antibiotics, could have been treated at home/ home hospital
- simple pneumonia, po antibiotics. Need to be admitted?
- on IV heparin, dressings for ulcers. Care could have been provided at home with sufficient HC
- home O2 needed; would have to pay for O2 plus extra personal care-need higher HC limits
- Home O2 (2)
- wait for home O2; waiting for NH in Ont
- palliative, delay waiting for home O2
- needs 24 hour at home; exceeds HC guidelines. Daughter unable to care for at home with available community resources.
- Receiving HC before admission; husband elderly, no family to help with care. Level of care exceeds HC guidelines, 24 hr. care

- no HC service available for 2 days, could not manage without same
- delays: family refused to take pt home until psychiatric assessment done; done, but then not enough notice to get HC on week-end; husband at Rehab, son away.
- existing HCNS pt, needing increased services
- pt. on week-end pass as trial for d/c with HC; increased needs
- needs higher HC limits. Had managed at home with HCNS but admitted as needed more frequent foot dressings

3. Palliative-30

- for palliative care / hospice (15)
- Hospice/ palliative. Massive CVA. Family unable to provide care at home.
- needs higher HC, hospice, palliative (3)
- requires split shift, terminal/palliative care
- palliative care, family couldn,t meet his care needs at home
- [redacted] - many could be home with higher HC limits, palliative/hospice
- [redacted] -pt. Would have benefitied from a long term hospice care facility- family unable to cope taking home.
- [redacted] - able to go home but required more help/ increased home care, unsure how long this will last (higher HC, palliative, Hospice) (2)
- palliative/hospice: lived alone, needs supervision, assistance as a safety measure
- palliative, terminal ca larynx, trach; family stress, could not keep him at home. Needs higher HC, social supports.
- elderly gentleman, lives alone, dying. Could be cared for in a hospice or at home with palliative HC 24 hours
- terminally ill-family refused to take pt. home, fearful of process leading to her demise. Family require ++ support, assistance in dealing with the inevitable.
- were caring for her at home, deteriorated. Need for higher HC limits, palliative

4. Respite-11

- required respite-family moving
- admitted for respite for daughter; need bathroom renovations
- respite for family (2)
- HC assessment for Respite
- Respite needed, caregiver strain; need for social supports
- higher HC, respite
- admitted for respite, requires supervision, mobilization, help with ADL
- complicated-daughter trying to care for both palliative parents at home
- respite, wife can't cope at home
- waiting for NH respite bed

III. Delay awaiting transfer to another facility: 99 entries

1. No bed available/accepting facility short staffed/wait for bed: 33 entries
2. Wait for Cardiac Services: 28 entries
3. Wait for Rehab: 25 entries
4. Wait for restorative care: 10 entries
5. Other: 3 entries

1. No bed available/accepting facility short staffed/wait for bed: 33 entries

- Accepting hospital short staffed
- Accepting hospital short staffed, couldn't accept child
- no bed
- no bed at Regional Hospital/staff (4)
- no bed at home hospital (2)
- Reg Hosp delay to take baby
- wait for bed at [redacted], not specified(7)
- to Halifax, Hepatology
- to [redacted]
- to [redacted] 5 day delay. [redacted] stated not aware of request for transfer.
- to [redacted] for surgery; could be home with HC
- for appointment in Moncton
- Cancer Clinic
- waiting cancer care in the city
- for tests in another facility
- returning to home hospital, RN refused transfer-5 day delay
- Halifax for vascular studies
- unable to reach family doctor to arrange transfer to home hospital
- no beds at preferred hospital
- to tertiary care
- waiting for transfer for psychiatric assessment
- Waiting for [redacted] appointment, did not require hospitalization to wait. Family & boarding home nervous about taking her back.
- appointment at [redacted], 10 days

2. Wait for Cardiac Services: 28 entries

- Halifax for Cardiac Cath/to [redacted] for cardiac cath: (11)
- to Halifax for Cardiac services/investigation (3)
- to [redacted] for bypass Surgery (3)
- Referral to cardiologist (4)
- for angioplasty (2)
- angiogram
- 9 day delay, [redacted] for angiogram
- 6 day, [redacted] for angiogram
- [redacted] Cardiology, 11 days
- [redacted] open heart Surgery

3. Wait for Rehab: 25 entries
- wait for rehab (13)
- rehab; requires mobilization, 24 hr care; lives alone
- rehab; could wait at home with higher HC limits
- Rehab; could wait at home with supervision, social supports, pt/ot
- [redacted] specified (9)

4. Wait for restorative care: 10 entries
- for restorative care (6)
- restorative care, [redacted] specified (4)

5. Other (3 entries)
- family refused transfer to Regional Hospital
- initially parents didn't want transfer to Regional Hospital
- Delay in discharge planning

APPENDIX 2 Survey Instrument

This survey instrument and the "cheat sheet" were printed back to back so that critical information was always available to the person filling out the survey, even if they didn't have access to the more comprehensive Questionnaire Guide.

NS Department of Health
Facilities Review Questionnaire
— Please refer to the Guide for detailed completion instructions —

Addressograph or Label

Name_____
Unit # _____ Hosp # _____
County of Residence _____
DOB YYYY/MM/DD Sex ☐ M ☐ F
Admit YYYY/MM/DD Discharge YYYY/MM/DD
Discharged ☐ Alive ☐ Deceased

1. Is this patient being transferred/discharged to another level/location of care (after waiting >24 hours)?
OR Could or should this patient be transferred/discharged to another level/location of care?

1.A Yes

Hospital Transfer
☐ For Tx/Dx ☐ Post Tx/Dx

Provincial Government Program
☐ NH ☐ Other LTC ☐ HC

Private Arrangement
☐ Self ☐ Family ☐ SH

☐ **Other**

1.B Yes, but
☐ Physical Problems ☐ Mental Health Problems
☐ non NS resident ☐ Other

1.C Additional resources required for discharge :
Check all that apply
Circle most important one

☐ Higher HC limits ☐ Supervision ☐ GP Post-D\C
☐ Meds/Supplies ☐ Palliative HC ☐ Hospice
☐ Respiratory Therapy ☐ Physio/OT ☐ Social supports
☐ Mental Health Services ☐ Other

— Complete # 2.A then STOP —

If other, specify

2.A Actual/est. date patient was ready YYYY/MM/DD

If other, specify

2.B Formal process begun (notice to assessor)
Yes ☐ Date YYYY/MM/DD ☐ N/A
No ☐ Patient refusal ☐ Family refusal
☐ Attending MD ☐ Other

3. Assessment by LTC/HC/DVA/Other
Yes ☐ Date YYYY/MM/DD **No** ☐

If other, specify

4. Date and Status of Assessment / Classification / Placement

Classification
Classified Date YYYY/MM/DD

Denied for LTC/HC/Other
☐ Care req. too low
☐ Care req. too high

Placement offered
☐ Refused, by patient or family
☐ Accepted ☐ Other

If other, specify

5. Funding required for placement
☐ Private ☐ Provincial public funding
☐ DVA \ VAC ☐ Other

If other, specify

Date YYYY/MM/DD | Completed by | Phone/pager number

Office use only | Unique ID | Questionnaire ID

The Cheat Sheet

Survey forms are to be completed at the time of discharge and on the last day of the survey on all discharges who meet the inclusion criteria, PLUS, all patients still waiting in hospital who would meet the inclusion criteria if discharged. Treat deceased patients as you would a regular discharge.

Inclusion Criteria

Is the patient making a transition to a different level or location of care (Discharge to nursing home, homecare, transfer to another hospital, *etc.*) ?	OR	Could the patient make a transition to a different level of care if certain services were available outside the acute care setting ?

AND

Has the patient been waiting for a period of greater than twenty-four hours for the required/needed care to become available ?

Alphabetic Hospital list	Hosp #
Aberdeen Hospital	11
All Saint's Springhill Hospital	12
Annapolis Community Health Centre	13
Bayview Memorial Health Centre	58
Buchanan Memorial Hospital	15
Colchester Regional Hospital	18
Dartmouth General Hospital	65
Digby General Hospital	20
Eastern Memorial Hospital	22
Eastern Shore Memorial Hospital	23
Fishermen's Memorial Site - Health Services Ass°	24
Glace Bay - Cape Breton Health Care Complex	75
Guysborough Memorial Hospital	27
Hants Community Hospital	37
Health Services Association of the South Shore	14
Highland View Regional Hospital	30
Inverness Consolidated Hospital	34
IWK Grace Health Centre	86
Lillian Fraser Memorial Hospital	32
Musquodoboit Valley Memorial Hospital	33
New Waterford Consolidated Hospital (CBHC)	63
North Cumberland Memorial Hospital	35
Northside Harbourview Hospital (CBHC)	41
Nova Scotia Hospital	77
Queen Elizabeth II Health Science Centre	85
Queens General Hospital	38
Roseway Hospital	39
Sacred Heart Hospital	47
Soldiers' Memorial Hospital	48
South Cumberland Community Care Centre	49
St. Mary's Memorial Hospital	45
St. Martha's Regional Hospital	43
Strait - Richmond Hospital	68
Sutherland Harris Memorial Hospital	50
Sydney - Cape Breton Health Care	73

Questions

1. If included per the study criteria above, where would the patient go?

1.A Answer **yes** if patient has waited >24 hours, or is still waiting on the final study day. Please indicate actual or planned discharge option.

1.B Answer **"yes, but"** for chronic, long-stay patients who are unsuitable/ineligible for currently available post-discharge services.

1.C Additional resources required for discharge – You may check more than one option but please circle the most important factor delaying/preventing this patient's discharge from your facility.

2.A Actual/est. date patient was ready - Insert the date you know (or estimate) that the patient would have been capable of being discharged had the required resources been ready or available.

2.B Formal process begun (notice to assessor) For patients where an external process (*i.e.* classification for LTC or assessment for HomeCare) must take place, please insert the date that the initial documentation was completed and the external assessors notified.

For patients where a formal external process is not involved, please estimate the date that the patient could / should have made a transition to a different level of care. Special cases: Inter-hospital transfer – use the date a bed was requested. Chronic long stay patients – estimate the date their condition stabilized.

3. What the date the assessment was started, *i.e.*, forms & patient were reviewed, *etc.* Answer *no* if the assessment has not started, or if no external assessment is required.

4. If a classification has taken place, please provide the date of classification, regardless of result.

5. What funding is required for placement?

APPENDIX 3 Instruction booklet

This booklet formed the basis for the educational sessions and was made available to all site coordinators, and, where applicable wards/services involved in completing the survey questionnaires.

Transitions in Care

NS Department of Health
Facilities Review
Questionnaire Guide

NS Department of Health
Facilities Review Questionnaire

Purpose To provide insight into the experience of facilities in terms of planning for, and arranging discharge of, persons whose health care needs are believed to be better suited for care in a different environment. This included situations where persons are awaiting transfer to other hospitals, or discharge to care in the community. The intent is to identify bottlenecks in transferring patients, to accessing existing post-discharge services, or to identify persons who cannot be discharged because of the lack of appropriate resources in the community. This first phase is concerned with the situation existing in acute care facilities. A planned second phase will focus on those services and facilities providing care post-discharge.

Authority The facilities review is being conducted under the authority of the minister of health.

Methods 1) A two-week "snapshot" of discharges of persons meeting the study inclusion criteria, plus a one day profile of persons still waiting for transfer/discharge. A short questionnaire is to be completed on a persons meeting the inclusion criteria during the two-week period.
2) Daily census information for each of the days during the study.

Confidentiality The information provided will be covered under the confidentiality provisions of the Hospitals Act and will be treated in a manner that ensures security of the information and guarantees confidentiality of the individuals concerned.

Analysis The analysis will look at the mix of patient types and transfer/discharge options in an attempt to identify areas lacking appropriate availability and/or types of discharge options. While some analysis may be done at the hospital level, of greatest interest will be comparisons done at the county/regional level and according to size/type of hospital.

Reporting The questionnaire results will be combined with other information to produce a report to cabinet.

Dissemination The report will be distributed to health boards, facilities and department of health departments responsible for programming and policy as well as to healthcare professionals.

Guide for Responses to the Facilities Review Questionnaire

Introduction

This guide is designed to help explain on whom the questionnaires should be completed and what each question means. The questionnaire itself does not provide much information on the questions or responses and **must be completed using this guide as a reference.**

General

If an addressograph or label is available, please imprint or attach in the upper right corner.
Insert your hospital # (refer to the list on the back of each survey form)
Please ensure we have county of residence (or province / country if non-resident of NS).
Complete admission date, discharge date (if applicable) and whether the patient was discharged alive.
Please choose only one (best) response to each of the multiple option questions except where indicated.
Note that some affirmative responses require the completion of a date.
For responses in the "other" category – please provide a brief explanation in the space provided.

When Should the Survey be Completed?

The survey strategy has two phases:

- For a two week period chosen by the participating hospital, survey forms are to be completed at the **time of discharge** on each patient who meets the inclusion criteria set out below.
- **On the last day of the survey**, forms are to be completed on all discharges who meet the inclusion criteria, PLUS, **all patients still waiting in the hospital** who would meet the inclusion criteria if they had been discharged on that last day.

Special note re deceased patients – if they meet the criteria below, treat them as you would a regular discharge.

Inclusion Criteria

Two questions must be asked to determine whether a patient should be included in the study or not:

- First, Is the patient making a transition to a different level or location of care (Discharge to nursing home, homecare, transfer to another hospital, *etc.*) ?

  OR

  Could the patient make a transition to a different level of care if certain services were available outside the acute care setting?

- Second, Has the patient been waiting for a period of greater than twenty-four hours for the required/needed care to become available?

Questions

1. Is the patient being, or should the patient be, transferred or discharged to another level of care (after waiting >24 hours), and if included per the study criteria above, where would they go?

1.A Answer **yes** if they are being discharged after waiting >24 hours, or if on the final study day they are still waiting.

For Tx/Dx	Transfer for diagnostic/treatment services not available in facility
Post Tx/Dx	Transfer after diagnostic/treatment services have been provided

NH	Nursing Home
Other LTC	Other long term care program operated by the Department of Community Services including: Regional Rehabilitation Centres, Adult Residential Centres, Group Homes, Residential Care Facilities, and Community Based Options (incl. Small Option Homes)
HC	Home Care

SH	Supportive Housing: Enriched living, Assisted Living
Family	Care by family
Self	Care by self

1.B Answer **"yes, but"** for chronic, long-stay patients who are ineligible for current post-discharge services by reason of a high level of care/supervision, etc, or because of residency requirements, if you think they should receive another level of care, but such services are not currently available. Please indicate the main reason:

Physical Problems	Main problem involves a physical diagnosis
Mental Health Problems	Main problem involves a psychiatric diagnosis
non NS resident	Non resident and therefore not eligible for services in NS

1.C **Additional resources required for discharge** – What additional community resources would be required for the patient to be discharged from your facility? Place a check mark beside those resources that are critical to being able to discharge this patient from an acute care setting and <u>circle</u> the option that you judge to be the single most important factor.

Higher HC limits	Care requirement exceeds current Home Care maximums
Supervision	May not require specific care but unsafe or inappropriate to be left alone
GP Post-D\C	Doesn't have a family physician to assume care in community
Meds/Supplies	Cannot afford or obtain necessary medications/medical supplies post D/C
Palliative HC	Palliative home care services
Hospice	Hospice Care
Respiratory Therapy	
Physio/OT	Physio or Occupational Therapy
Social Supports	Lacks family / friends who could assist with care/supervision needs
Mental Health Services	Intensive community-based mental health treatment and support

2.A **Actual/est. date patient was ready** - Insert the date you know or estimate the patient would have been capable of being discharged had the required resources been available.

2.B **Formal process begun (notice to assessor)** For patients where an external process (*i.e.* classification for LTC or assessment for homecare) must take place, please insert the date that the initial documentation was completed and the external assessors notified. We will be using this date and the assessment date in Question 3 to determine the response time by LTC/HC assessors, so, in order to be fair, please try to indicate the date on which they were notified.

For patients where a formal external process is not involved, please estimate the date that the patient could / should have made a transition to a different level of care. Special cases: Inter-hospital transfer – use the date a bed was requested in the other hospital. Chronic long stay patients – estimate the date their condition stabilized and they started receiving care intended only to maintain them in their current state.

3. **Has this patient been assessed by LTC/HC/Other?** Many discharge processes require assessment by external organizations, e.g., LTC assessors, Home Care assessors. If the patient has been assessed, we would like to know the date the assessment was started, *i.e.*, forms & patient were reviewed, *etc.*

Answer *no* if the assessment has not started, or if no external assessment is required.

4. **Status of Assessment / Classification** This question allows you to indicate whether assessments / placements are still "in process," or to provide the results of a completed assessment. If a classification has taken place, please provide the date of classification, regardless of result.

Care req. too low - Judged to have care requirement too light to require nursing home
Care req. too high - Care level too high - Judged to have care needs beyond Level II capacity

Classified, awaiting placement - Patient has been classified as appropriate and is waiting for an opening in an appropriate facility. Please provide the date the classification took place.

Response to placement offer by patient or family.

5. **What funding is required for placement?** Please indicate the source of funding if the patient will be accessing a Nursing Home or similar arrangement.

Finally, please enter the form completion date, identify yourself, and give us a number where you can be reached if we have a question about the survey form.

— Thank you very much for your cooperation —

APPENDIX 4 Census forms

The following page has an example of the daily census forms used to determine the denominators for occupancy rates in the survey hospitals. There were four weeks surveyed, the example is for only one of the weeks.

Facility Census Summary Sheet

Date	Med/Surg/ICU/ Paeds/GAU/Gyn		Obstetrics exclude bassinets		Mental Health		Addiction Programs				Long Term Care		Others - Specified				Other - Please ID		Other - Please ID	
							Detox		28-day				Restorative Care		Rehabilitation					
	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open	Beds Occupied	Staffed & Open
November 30																				
December 1																				
December 2																				
December 3																				
December 4																				
December 5																				
December 6																				

Facility/Site Name: _____

Census Report Completed by: _____

Phone Number at which you may be contacted for any questions: _____

Please identify the number of staffed beds, i.e., beds in operation on each day of the survey. The number may change during the survey pe

Separate totals should be reported for

- *medical/surgical including ICU/CCU, step-down, paediatrics, etc.*
- *Obstetrics - excluding bassinets*
- *Acute Psychiatric/Mental Health beds*

Instructions: Please fax this completed census form by noon, Tuesday December 7 to Barb Harvie/Maureen Aucoin at 424-0663

Questions should be referred to Barb (424-0972) or Maureen Aucoin, 424-3078 in Health Information at DOH

Facilities are encouraged to adapt this form to meet their particular needs, e.g., you may want to ID the number of patients waiting in the ER for beds

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Transitions in Care

Nova Scotia Department of Health
Facilities Review

Volume 2

Review of Nursing Home Beds

Prepared for:
the Honourable Jamie Muir
Minister of Health

March 2000

NOVA SCOTIA
Department of Health

A Review of the Utilization of Nursing Home Beds

Prepared by the Subgroup on Nursing Homes:

Lloyd Brown
Donna Dill
Graham Hardy
Soili Helppi
Wade Were

Submitted to:

Mr. Bob St. Laurent,
Chairperson, Health Facilities Review Planning Team

Submitted on:

February 9th, 2000

Executive Summary

As part of the Health Facilities Review, a Subgroup on Nursing Homes was formed to identify key factors that may impact the appropriateness of Nursing Home placements and recommend courses of action to address these factors. Over a two-month period, the Subgroup examined existing sources of Nursing Home data, conducted a literature review, and reviewed Nova Scotia's overall system of Nursing Home services.

Although sufficient data was not available to determine the number of Nursing Home residents who may have been more appropriately served in an alternative setting, the Subgroup was able to identify three major systemic characteristics that may not support the most cost-effective use of Nursing Home beds. In particular the Subgroup has reviewed the way Nursing Home beds are accessed, the funding of Nursing Homes, and the planning of a broader range of "continuing care" services including Nursing Homes.

Despite a limited pool of licensed Nursing Home beds in the Province, admission to beds is not guaranteed to be based on need alone. Access can vary depending on the individual's ability to pay, and an exploration of the most appropriate care alternatives is not assured prior to making a Nursing Home placement.

The system of funding Nursing Homes, involving a flat per diem rate, does not adequately recognize the variable care requirements of residents. A disincentive exists for Nursing Homes to accept applicants with higher care needs.

Under the government's current accountability framework, planning for continuing care services has tended to be fragmented and conducted more on a program by program basis. In the absence of a system- wide approach to planning the broad array of continuing care services, achieving the right mix of service options is jeopardized. In fact, a Canada wide review of continuing care programs illustrates several continuing care services that are not available or only partially developed in Nova Scotia.

Initiatives are underway to ameliorate each of these three systemic deficiencies. Firstly, the government has announced its commitment to a single entry system. The single entry model, as it has been developed in most other provinces, includes a single entry access mechanism, coordinated assessment and placement, and coordinated case management. Under this system of access, only those applicants who have a demonstrated need will be considered for Nursing Home placement.

Secondly, the Department of Health has announced a Demonstration Project to test the Resident Assessment Instrument and its associated case mix classification system called the Resource Utilization Grouping (RUG) system. The RUG system produces valid and reliable case mix data that is needed to develop a funding system that allows for the equitable distribution of resources based on a recognition of the variable care needs of nursing home residents.

Thirdly, as part of the government's commitment to work toward the full integration of the Departments of Health and Community Services as it relates to continuing care, the Departments are engaged in discussions regarding program responsibilities and accountabilities. Also, the Department of Health is reorganizing itself to support a better integration of continuing care programs. These initiatives are indication that the government is moving toward an accountability framework that will maximize the probability that planning and resource allocation for continuing care will be conducted on a system wide basis. Such an approach to planning is critical to determining the appropriate mix and levels of institutional, home and community based programs.

The Subgroup supports the initiatives taken by government as outlined above and further recommends the following:

- It is recommended that in the early stages of implementing single entry, government introduce a policy requiring all nursing home applicants be classified prior to admission. Concurrent with the introduction of this policy, government should collaborate with the Nursing Home sector to develop a province-wide waitlist management policy and associated information system.

- It is recommended that the Department of Health begin to develop a Nursing Home financing system capable of utilizing the Resource Utilization Grouping system's case mix classification data.

- It is recommended that the Department of Health explore the development of continuing care services that are currently only partially available or not available. In addition to Adult Day Support and Respite Services, the Department should consider: Palliative Care; Chronic Care Units/Hospitals; (Geriatric) Assessment and Treatment Centers & Day Hospitals, Crisis Programs; and Community Physiotherapy and Occupational Therapy. In pursuing the development of continuing care services, the Department should examine closely any available cost-effectiveness research, and commission its own research as needed.

- It is recommended that the Department of Health cautiously approach the expansion of "facility based" continuing care programs eg. Nursing Homes, and fully consider how the continuing care needs of the population may be met through alternative continuing care programs. In addition to strengthening "home based" services, the Department should work with other government departments to enhance the system's capacity to offer "supportive housing" service options to fill the gap between independent living and facility care.

- It is recommended that the Department of Health develop "Bed Planning Guidelines" for the allocation of new licensed nursing home beds. The work of the now disbanded Long Term Care Working Group's Subgroup on Bed Planning Guidelines should be consulted.

Table of Contents

I. Introduction

Upon assuming office, the Nova Scotia government stated that the province would:

> *"In Partnership with health care providers, immediately undertake a comprehensive assessment of all health care facilities in order to ensure that Nova Scotians are receiving the right type of care in the appropriate facility. This review will be completed within 90 days of forming government. Implementation of recommended changes will begin immediately so that patient needs are properly met while providing cost-effective service delivery."*

The underlying intent of this initiative was to develop a more cost-effective system of service delivery to ensure that Nova Scotians would receive the necessary care in the most appropriate setting and in a timely manner.

Recognizing that like hospital patients, a portion of Nursing Home[1] residents may be more appropriately served in alternative settings, it was decided that Nursing Homes should also be examined as part of the overall Health Facilities Review initiative. A subgroup of the Health Facilities Review Team was formed involving staff from the Long Term Care Program, and two Nursing Home administrators appointed to the Subgroup by the Nova Scotia Association of Health Organizations and the Continuing Care Association of Nova Scotia. The Subgroup was to review the annual Nursing Home licensing report data and Nova Scotia's system of providing Nursing Home service in general. The purpose of this review was to identify the key factors that may impact the appropriateness of Nursing Home placements and to recommend courses of action to address these factors.

II. Overview of the Administration of Nursing Homes in Nova Scotia

Nursing Homes in the province are all independently operated. Homes are either owned and operated by private-for-profit enterprises, not-for-profit organizations, municipal governments, or Regional Health Boards/Non-Designated Organizations. The Provincial Government does not own or operate Nursing Homes.

The Long Term Care Program has not been devolved to the Regional Health Boards. The Department of Health is directly responsible for setting policy/standards, providing financial assistance to residents of Homes, and monitoring Nursing Homes.

The Long Term Care Program is primarily guided by two pieces of legislation:

1. The Homes for Special Care Act and Regulations give Health the authority to annually approve each Nursing Home's budget, per diem rate charged to the resident,

[1] The term "Nursing Homes" is used throughout this document to include Homes for the Aged.

and bed capacity. Other functions carried out by the Program under the authority of this legislation include: setting standards; licensing and inspecting homes; and determining eligibility for Nursing Home placement also known as "classification".

2. The Social Assistance Act and Regulations outlines parameters for providing financial assistance to individuals in financial need.

The process for determining eligibility for financial assistance and placement in licensed Nursing Homes is covered by the "Community Supports for Adults Policy" which is jointly administered by the Departments of Health and Community Services.

On behalf of the Department of Health, the assessment of the care and financial needs of applicants seeking Nursing Home subsidy is conducted by the Department of Community Services staff located in every county of the province. The DoCS staff also assess the needs of applicants to the Department of Community Services programs.

III. Quantifying the Appropriateness of Nursing Home Placements

In this section, the results of the review of the annual licensing report data are analyzed. This data was found to be of very limited use for addressing the question of appropriate Nursing Home placements for two main reasons: it is aggregated at the facility level and not resident specific; and survey responses are not sufficiently standardized. The findings are presented to briefly describe the Nursing Home population and to illustrate the need for better data. In the latter part of this section, the challenge of determining appropriateness of Nursing Home placements is discussed.

a. A Review of the Annual Licensing Report Data

All Nursing Homes must be licensed by the Minister of Health. Inspections are carried out at least annually. As part of the inspection process, the Nursing Home is expected to complete a survey document. By completing this survey, the facility provides the inspector the data they need to determine whether the facility is meeting the regulations under the *Homes for Special Care Act*. The survey also provides statistical data on residents, staffing, etc. This data is captured in paper form and not regularly entered in a data base. Therefore, the Subgroup had to arrange data entry of the relevant sections of the most recent surveys from the 70 homes. The period covered was Oct 22, 1998 to December 2, 1999. Only one time before had a year's worth of inspection surveys been inputted to a database. That period was September 30, 1996 to December 10, 1997. The two periods will be herein referred to as 1998/99 and 1996/97 respectively.

There are 70 licensed Nursing Homes in the province. The majority of Homes are stand-alone facilities, however, seven are based in hospitals. Homes range in size from 8 to 538 beds. The total number of Nursing Home beds in the province is 5,832 with an additional 82 beds designated for short respite stays. **See Appendix 1 for more details.**

An examination of the licensed beds per 1000 population 75+ years of age, illustrates variable levels of supply across counties. Using 1996 census figures projected to 1998, and the current approved Nursing Home beds, the provincial average is 102 Nursing Home beds per population 75+ years of age. Rates range from as low as 65 in Colchester County to as high as 157 in Victoria County. **See Appendix 2 for more details.** These ratios have limited utility in bed planning as they are insensitive to some important factors such as migration patterns of the frail elderly, the availability of alternative services such as other residential care facilities supportive housing, home care, and other community based programs.

Comparisons with other provinces are also somewhat limited in utility because long term care services are provided differently in each province, thus, ratios are not calculated on the same basis. For instance, some provinces have chronic care programs and some do not. To compare Nova Scotia's Nursing Home ratio against Ontario's, one would have to determine what proportion of Nova Scotia's Nursing Home residents would fit Ontario's definition of chronic care, and thus be removed from the calculation of the ratio. Data is not available to enable such a calculation. Because of our similar Nursing Home services, the PEI and New Brunswick could serve as reasonable points of comparison. PEI reports a bed ration higher than Nova Scotia while New Brunswick is lower.

Nursing Home Beds per 1,000 Population 75+ Years of Age	
Province	**Ratio**
Nova Scotia	102
Prince Edward Island	108
New Brunswick	91
Sources: NS – 1998 Statistics Canada Population Estimates *PEI – Personal Communication, Dept. of Health & Social Services (1998 Pop. Estimates)* *NB – Personal Communication, Dept. of Health & Community Services (1997 Pop .Estimates)*	

Average annual occupancy rates indicate the level of vacancy in Nursing Homes. Homes with occupancy rates of 98% or higher indicate a very high demand for beds. For these homes, beds are vacant for very short periods while discharge and admission arrangements are made. Only 10 homes reported annual average occupancies under 99%. Six homes were in the 97.9% to 98.9% range. One home was 97% and one was 96%. The home that reported 96% was a very small facility in a very remote community. The home that reported 97% is being monitored and may be considered for bed reductions. One home was at 91% and its bed capacity has been subsequently reduced. Another home reported 90% occupancy, however, when the beds designated for the exclusive use of Level 1 residents were removed, the home reports an occupancy rate in the 99% range. In general, the occupancy levels of Nursing Homes indicate that a high level of utilization with very little vacant bed days. **See Appendix 3 for more details.**

Turnover rates are considered indicators of the care levels of Nursing Home populations. Measured as a ratio of admissions over licensed beds, a high turnover rate is thought to be associated with a caseload of high care needs. However, this measure is somewhat confounded by such factors as inter-facility transfers. After removing the effect of inter-

facility transfers, the average turnover rate for all Nursing Homes in the 1996/97 survey period remained unchanged when compared to the 1998/99 period. The average (adjusted) annual turnover rate is approximately 31% which could be translated to an average length of stay of about 3 years. Only 17 homes had turnover rates under 20%, the majority of these are clustered in Pictou County (3) and on Cape Breton Island (11) and the remainder are scattered throughout the Western Region (3) **See Appendix 4 for more details.**

Residents of Nursing Homes are predominately made up of seniors. The age group 65+ years of age make up 94% of all Nursing Home residents, in fact, 84% are 75 years or older. The average age is 83. Women make up 73% of the resident population. **See Appendix 5 for more details.**

All Nursing Homes provide Type 1 and Type 2 care. Type 1 entails assistance and/or supervision with activities of daily living (ADLs). ADLs include such personal tasks such as personal hygiene, eating, toiletting, etc. Type 2 entails nursing care and/or nursing supervision. Typically, Nursing Homes admit applicants who have Type 2 care needs, however, some Type 1 applicants with relatively high care needs, or those with a prognosis of increasing needs in a short time period, will also be approved for admission.

About 84% of Nursing Home residents are reported to have Type 2 care needs. However, reporting irregularities reduces confidence in this figure. Some homes do not report updated care level classifications. Due to physical design issues, five Nursing Homes have wings that are restricted for residents with Type 1 care needs only. They represent 254 beds of the Nursing Home beds available in the province. Discounting the designated Type 1 beds, it appears that approximately 12.7% of Nursing Home residents have Type 1 care needs and occupy Nursing Home beds that can be used for Type 1 or Type 2 residents. **See Appendix 6 for more details.** The licensing data is insufficient to determine what percentage of the Nursing Home population could be more appropriately served in a lower care level setting.

The majority of Nursing Home residents experience multiple health problems which adds complexity to meeting their individual care needs. Half of Nursing Home residents have been diagnosed with some form of dementia, Alzheimer's Disease being the most common form. **See Appendix 7 for more details.** Other commonly reported diagnoses consist of hypertension, diabetes, stroke, and arthritis. Homes report that 12% of residents live with a psychiatric diagnosis (e.g. depression, anxiety disorders, schizophrenia). Diagnosis information is more descriptive than it is useful in understanding the functional impairment or care requirements of residents.

Measures of an individual's ability to do basic tasks for oneself (activities of daily living-ADLs) are strong determinants of the need for facility based long term care. Late loss ADLs such as eating, toiletting, and mobility are those which elders are most likely to lose late in life and are contrasted with early loss ADLs such as bathing and dressing. ADL loss tends to follow a pattern and most individuals with late loss problems will have already lost their independence in early-loss ADLs. While the lack of ADL deficits may

be an indicator of inappropriate placement, other aspects besides residents' ADL should be analyzed before drawing such conclusions (Ikegami et al, 1997).

Data from the licensing inspection reports show that approximately 59% of residents need assistance to mobilize and/or transfer, 59% are incontinent, and 43% need to be fed or require assistance or supervision with feeding. **See Appendix 8 for more details.** However, this data cannot be used to assist in the determination of appropriate Nursing Homes placements because it is collected in aggregate form.

b. The Challenge of Identifying Appropriate Nursing Home Placements

Determining what constitutes an appropriate placement in a Nursing Home is a complex matter involving, a careful consideration of the individual's level of functional impairment, and the individual's access to resources such as family care givers, accessible housing, and other supportive services available in the community.

Standardized assessment data on Nursing Home residents in the province would be required as a first step in measuring the appropriateness of placements. To obtain standardized assessment data on a representative sample of Nursing Home residents in the province, one must utilize a valid and reliable assessment tool, recruit and train nurse assessors in the use of the tool, and conduct assessments at Nursing Homes throughout the province. Although possible to undertake, such an endeavor would be costly and time consuming and was not permissible given the time frame allotted for the Health Facilities Review.

Secondly, clear definitions of what is considered low care or high care cases would also need to be established. Expert opinions would be needed in creating the definitions. The definitions would be shaped by the availability and scope of alternative services. For instance, if home and community based services were well developed in a particular area, then Nursing Homes in that area would care for residents with relatively higher care needs. If appropriate service alternatives do not exist or if the individual is isolated with little or no informal support system, then the Nursing Home placement may be the best option even when the individual's care needs are lower than what is normally supported by Nursing Home care.

In reviewing the literature, two studies were identified that attempted to measure appropriate placement in Nursing Homes in the lower levels of care. In a one study (Spector, Reschovsky, and Cohen, 1996), the authors used data from a nationally representative survey of long term care facilities and residents in the United States to estimate the number of Nursing Home residents who could be diverted to lower levels of care. Lower levels of care consisted primarily of home care, supportive housing options, and other community based services such as adult day programs. Using the most "conservative" of three sets of criteria for determining low care needs, they found that 15 percent of Nursing Home resident could be diverted to lower care levels. It should be

noted, however, that Nursing Home case mix has increased since 1987 when the data was collected. There would likely be fewer residents with low care needs today.

Another study (Ikegami, Morris, and Fries, 1997) examined low care cases in long term care settings in Denmark, Italy, Japan, Sweden, and the USA by using data collected with the Resident Assessment Instrument (RAI). The RAI is a standardized assessment tool federally mandated in the United States and used in several other countries including Canada. According to their most conservative or restrictive criteria, the researchers found between 2-14% of residents had low care needs. However, the authors recognized that definitions of low care cases depend on the availability of other service options. They noted that with sufficient provision of medical and social support, it may be possible to care in the community for residents with even some of the highest care needs.

Even if government had access to data that could be used to reliably quantify the level of inappropriate Nursing Home placements, it would not be feasible to discharge many Nursing Home residents as the Nursing Home has become their home and they have little to return to in the community. Furthermore, individuals who may not have needed a Nursing Home at the time of their admission may now require such services if their condition has deteriorated and circumstances changed.

While these studies addressed the matter of low care cases in Nursing Homes, inappropriate Nursing Home placements may occur at opposite ends of the care spectrum. That is, individuals may have care needs that are too low or too high for Nursing Homes. Some individuals will be appropriately admitted to Nursing Home and subsequently become in need of more intense care that exceed what is normally provided in Nursing Homes. However, the absence of a formal chronic care program in Nova Scotia means that these individuals must continue to be cared for in the Nursing Home setting or be admitted to medical beds in hospital. To quantify the number of Nursing Home residents who may be more suitable for a chronic care program would require valid and reliable assessment data and a clear definition of the client group that would be served by a chronic care program. Again, our current information system does not provide us the data to conduct such analyses.

IV. Key Factors that may Impact Appropriate Nursing Home Placements

Although the Subgroup was unable to quantify the extent of inappropriate Nursing Home placements, it is believed that certain key characteristics of our Nursing Home system may not be supporting the most cost-effective use of our Nursing Home beds. In particular, the subgroup has reviewed the way Nursing Home beds are accessed, the funding of Nursing Homes, and the planning of continuing care[2] services including Nursing Home beds. In this section, a qualitative review of each of these key areas is

[2] Continuing care is a term that is generally used to describe a system of service delivery... . The term reflects within it two complementary concepts: that care may "continue" over a long period of time, and that an integrated program of care "continues" across service components, that is, there is a continuum of care from community services such as Meals-on-Wheels to care in geriatric units in acute care hospitals." (Hollander and Walker, 1998).

provided to illustrate how each factor may impact the appropriateness of Nursing Home bed placements.

a. Accessing a Nursing Home Bed

Access to Nova Scotia's Nursing Homes can vary depending on the individual's ability to pay. The majority of people seeking access to Nova Scotia Nursing Homes require some form of public assistance to cover the per diem charges. These individuals make their application through the district office of the Department of Community Services where eligibility for care is assessed and financial assistance is determined.

Some Nursing Homes in Nova Scotia will accept applications for admission directly from applicants if they have the ability to pay the full per diem for at least 18 months. Despite a limited pool of licensed Nursing Home beds in the Province, admission to Nursing Homes in the province is not guaranteed to be based only on need. For some homes, private pay applicants can bypass the waiting list process and access vacant beds more quickly than those applicants who require public assistance.

Despite the lack of a provincial policy, many Nursing Homes insist that all applicants, regardless of ability to pay, be assessed and classified through the provincial government system to determine eligibility to a Nursing Home. **See Appendix 9 for more details.** If the Nursing Home accepts the applicant before knowing whether he/she is eligible for public assistance, and it is subsequently found that the applicant is ineligible, and he/she refuses to pay privately, then the home is left with a bad debt and the sensitive matter of needing to discharge a resident against their will.

Nursing Homes that Require All Applicants be Classified Prior to Admission		
Region	**Total # of Homes**	**# of Homes - All Applicants Classified**
North	15	3
Central	12	5
Eastern	23	23
Western	20	19
Province	70	50
Source: Telephone Survey conducted by the Department of Health, January, 2000.		

In the current intake system, an exploration of the most appropriate care alternatives is not guaranteed prior to consideration of Nursing Home placement. For instance, the option of home care services is not necessarily fully investigated. If the applicant/family, the physician, and/or the case worker does not fully understand or is unwilling to accept home care options, the appropriate least costly option of home care may not be pursued. By using two separate assessment processes, one to determine home care services and one to make Nursing Home placements, our system of assessment may be contributing to premature institutionalization.

Unlike those seeking public assistance, the Department of Health does not require private pay applicants to undergo the provincial standard assessment. All Nursing Home applicants seeking public assistance must be assessed by a physician using Form A "Medical" and undergo a social assessment by a Department of Community Services case worker using Form B. The Case Worker uses information from Form B to determine eligibility for financial assistance.

The full assessment is then reviewed by the Case Worker to determine which Government Department it should send it to. For clients best suited for a Residential Care Facility (Type 1 Care), the file is sent to the regional classification officers in the Department of Community Services. Alternatively, for clients best suited for Nursing Homes, the file is sent to Department of Health Classification Officers in Halifax. If the applicant falls in a "grey" area, the Case Worker may choose either Department rather than pursuing the least cost alternative that meets the applicant' needs.

The Classification Officers review the assessment information, seek clarification when necessary, and determine eligibility on the basis of care requirements. The determination of eligibility involves checking information against the Department of Health's Guidelines for those not eligible for Nursing Home placement, and calculating the applicant's level of care classification score. Most applicants scoring 9 points or more may be approved for admission to a Nursing Home. Under special circumstances, people who score less than 9 points may be admitted. The Classification Officer completes a Form C notifying the Case Worker of the classified care level and their eligibility for Nursing Home placement. The Classification Officer is the sole person determining whether the individual should be placed in a Nursing Home, although their decision may be appealed to the Licensing Coordinator in the Department of Health. The Classification Officer is not involved in setting priorities for placement or managing the waitlists.

It has long been recognized that the Department of Health's system of determining eligibility relies on an outdated assessment form and a classification process involving a large degree of subjectivity. In particular, the forms are not strong in the areas of assessment pertaining to mental health, behavioral problems, social supports, and living environment.

The Case Worker is unable to keep a comprehensive list of those awaiting placement for private Nursing Homes which permit private pay clients to bypass the classification process and apply directly. The 30 District Offices of the Department of Community Services are each supposed to keep waiting lists. In some cases, more than one District Office shares the same waiting list i.e. Cape Breton County. How the Districts organize the waiting lists can vary as there is no provincial waitlist management policy. Most often, the priority for placement goes first to "Adults in Need of Protection" under the Adult Protection Act. Subsequent priorities can vary from District Office to District Office. Priorities are established for the following categories: those in hospital awaiting placement, those in a crisis situation living in the community, those non-urgent cases living in the community, and those awaiting an inter-facility transfer. Additionally,

separate waiting lists are often kept by Nursing Homes. With each list being kept using different policies/procedures, even if collated, these lists would result in little information useful for management.

The pressure from acute care facilities to discharge patients to Nursing Homes is great in many areas. The cost of maintaining a person in hospital is considerably higher than that of a Nursing Home. However, a practice of placing those in hospital first before those clients in community can lead to greater hospital admissions as those in the community deteriorate and see their fast track to the Nursing Home is through the hospital.

Hospitals who are trying to clear their beds of people who do not need them find that some patients are not willing to take the first available Nursing Home bed because they fear that they will be stuck in a home some distance from their family and friends. Hospitals cannot point to a policy of inter-facility transfer that provides assurances to the patient that his/her name will remain on a single and fair chronological placement list. Inter-facility transfers are typically are low priority.

Those on the waiting list are not necessarily prepared to take a bed in their choice facility when it becomes available. Rather, they have applied with the thought that they may need a Nursing Home down the road, and if and when this happens, they want their name at the top of the list. These precautionary applications inflate waiting list numbers. The absence of accurate waiting lists reduces the system's ability to appropriately manage the supply of licensed beds.

The existence of a vacancy in a Nursing Home does not always mean that the space is suitable for the number one application on the homes/DoCS's waiting list. Many factors must be considered. Since most Nursing Home beds in the province are not in private rooms, the sex of the applicant, and to some extent their compatibility, must be considered when locating residents in the same room. The applicant's cognitive function must also be considered when placing an applicant. Some will require a secure area with special programming if they are at risk due to certain behaviors. Also, available staffing levels and space must be consistent with the applicants care needs. Some will require heavy care and cannot always be accommodated on lighter care wings. In other cases, the applicant will need specialized equipment that will require suitable space that is not always available in shared rooms.

b. Funding Nursing Homes

Unlike physician and hospital services, Nursing Home care is not an insured service. The resident is responsible for the full cost of their care and accommodation. The average un-weighted per diem is $105.39 (effective October 1, 1998). **See Appendix 9 for more details.**. If the resident cannot afford to pay for needed care, they may be eligible for subsidy under the Social Assistance Act. Twenty-one percent (21%) of Nursing Home residents are paying the full per diem themselves while the remaining portion (79%) requires some level of government subsidy to supplement their pension incomes **See**

Appendix 10 for more details. In the 1998/99 fiscal year, the overall approved budget for licensed Nursing Homes was $216 million. Public funds covered sixty-one percent (61%) and resident contributions are responsible for the remaining portion (39%).

Each Nursing Home submits a combined operating and capital budget to the Department of Health for review. The Department approves the overall budget and calculates the per diem rate that the facility can charge its residents. Each facility is assigned one or more unique per diem rates. Most facilities have one flat rate while some facilities are assigned two or three rates that vary according to the care levels of the residents.

However, it should be noted that the care levels classification system is inadequate for funding purposes. It relies on overly subjective assessment data and an imprecise set of care levels. The validity and the reliability of the classification system is highly suspect. Further, there is a weak link between care levels and funding allocations.

Although the Department of Health sets the per diem rates that facilities may charge their publicly assisted residents, homes can, and in some cases do, charge private pay clients a higher rate. This creates an incentive for homes to admit private pay applicants before publicly assisted applicants regardless of the care needs of individuals. Some Homes use the additional revenue collected from private pay applicants to finance new programs that benefit their residents that are not recognized by government.

By paying most Nursing Homes a flat per diem rate for all residents regardless of care need, homes find it necessary to approve only those applications for admission that will allow them to maintain or reduce their case mix. For instance, if a home discharges a resident with light care needs it must replace that resident with a light care applicant. In fact, many homes dedicate and staff wings according to care levels, i.e. a vacant bed in a light care wing is not filled with a heavy care application. Nursing Homes are not intentionally accepting lighter clients for financial gain, rather they are simply managing within a limited budget allocation.

The combination of an inadequate pre-admission screening process coupled with a funding mechanism that pays Nursing Homes a flat per diem, creates an incentive to admit light-care cases. Such cases require relatively little staff time and the payment for their care will be that of an average (and heavier care) resident. The nature of our current funding system does not create a desired set of incentives for appropriate utilization. Essentially, Nursing Homes have little incentive to admit the clients with the greatest care needs.

Another impediment to discharging individuals from hospital to nursing may exist due to the difference between insured hospital services and non-insured Nursing Home services. Because most hospitals do not charge individuals who overstay their need for hospital services, an incentive is created to stay in hospital instead of accepting a Nursing Home bed where they will be expected to pay a per diem charge. Although under Section 11(1) of the *Hospitals Act*, hospitals have the ability to bill patients for services rendered after

the patient has been medically discharged but still occupying a hospital bed, hospitals do not regularly use this provision for patients awaiting transfer to a Nursing Home.

In provinces, west of New Brunswick, the distinction between insured hospital services and non-insured nursing home services is not so severe as it is in the Atlantic Provinces. In the west, the cost of nursing home services is partially insured. Generally speaking, the care component is insured and room and board costs are borne by the resident. The relative high cost of Nursing Home services to clients in Nova Scotia may serve as a deterrent to premature admissions, however, it may hinder attempts to move patients out of insured hospital beds and into non-insured Nursing Homes.

c. Making Available the Right Mix of Service Options

The range of continuing care service options available in each province varies and terminology used to describe service options is not common across jurisdictions. Hollander and Walker (1998), on behalf of the Federal/Provincial/Territorial Ministers of Health, authored a report that outlines the key continuing care service components found in Canada. Through a consensus process, a set of definitions were developed for each component.

In **Appendix 11**, definitions for each of the key continuing care service components are provided. Each definition is followed by a statement indicating the status of the component's development in Nova Scotia. The definitions have been organized under two sections: available in Nova Scotia and partially or not available in Nova Scotia. These analysis provides an easy-to-grasp reference for those who wish to understand the scope and gaps of continuing care service components in the in the Nova Scotia system.

Continuing Care Service Components Available in Nova Scotia	
Available	**Partially or Not Available**
Assessment and Case Management	Adult Day Support
Long Term Care Residential Facilities (called Homes for Special Care in NS)	Respite Services
Group Homes	Palliative Care
Life & Social Skills for Independent Living	Chronic Care Units/Hospitals
Congregate Living Residences	Assessment & Treatment Centers & Day Hospitals
Home Nursing Services	Community Physiotherapy & Occupational Therapy
Homemaker Services	Crisis Support
Equipment and Supplies	
Meals Programs	
Transportation Services	
Support Groups	
Volunteers	
Source: Hollander and Walker (1998)	

The utilization of Nursing Home beds is partly dependent on the availability of other available service options. If no other options are available, individuals may apply to a Nursing Home before they want or need such services. For instance, a senior with early

stage dementia may require 24 hour supervision but not require nursing services available at a Nursing Home. This person may be more appropriately served in a small congregate living environment, however, if no such option is available within a reasonable distance from the person's family, friends, and community, the person may be admitted to the local Nursing Home.

One of the greatest challenges facing governments as it relates to the introduction of publicly funded continuing care options is the paucity of cost-effectiveness studies. Ideally, new or expanded services should be supported by sound cost-effectiveness information. The need for such information is becoming increasingly recognized nationally. For instance, a major program of research is examining the cost-effectiveness of home care in Canada as an alternative to care provided in long term care facilities and acute care settings. The preliminary findings show that the costs of home care are about one-half to three-quarters the cost of facility care across all levels of care. However, within each level of care, potential cost savings are greatest when home care clients are fairly stable (Hollander, 1999).

Continuing care services are provided by a patch-work of government agencies and departments, private-for-profit facilities and other non-for-profit facilities and agencies. The responsibility for providing continuing care services is primarily shared between two provincial governments: the Department of Health and the Department of Community Services. To illustrate the mix of responsibilities for the components of continuing care in Nova Scotia, the following table has been assembled based using Hollander and Walker's terminology for services identified as "available" in Nova Scotia;

Responsibilities for Continuing Care Service Components in NS			
Dept. Health	**Dept. Community Services**	**Shared DoH-DCS**	**Other**
Home Nursing Services	Group Homes	Assessment and Case Management	Meals Programs
Homemaker Services	Life and Social Skills for Independent Living	Long Term Care Residential Facilities (called Homes for Special Care in NS)	Transportation Service
		Equipment and Supplies	Support Groups
			Volunteers
			Congregate Living Residences
Source: Terminology is from Hollander & Walker (1998); The Subgroup (author) has categorized terms.			

Under the current accountability framework and organizational structure, planning for continuing care services has tended to be fragmented and conducted more on a program by program basis rather than a system-wide approach. To date, efforts aimed at developing a provincial vision for continuing care have been unsuccessful.

V. Ensuring Appropriate Use of Nursing Home Beds

In the following section, suggestions for ameliorating system deficiencies relating to access, funding, and planning are discussed. The suggestions are not new. In fact, many initiatives are already underway which are consistent with the points offered below.

a. The Single Entry Model

Unlike most other provinces, Nova Scotia does not deliver continuing care services through a single access point. Access to services can be confusing, inconsistent, and time consuming for individuals and families seeking assistance. As a result, individuals may access Nursing Home services without fully understanding less costly and less intrusive service options that can meet their needs.

The single entry model involving: single entry access; coordinated assessment and placement; and coordinated case management has been identified by Marcus Hollander (1994) as key system characteristics (or best practices) for an efficient and effective continuing care system. A well developed and implemented single entry model will ameliorate many of the current shortcomings of our existing system of access to continuing care services.

Using the single entry model, the following benefits may be realized (Health and Welfare Canada, 1988):

- The full range of community and facility options are considered for each individual.
- Remedial conditions are identified and treated.
- Access to services is controlled through the consistent application of priorities and eligibility criteria.
- Individuals are appropriately referred to services based on their level of need, thereby, reducing the risk of under-servicing or over-servicing.
- Inappropriate institutional placement is avoided to clients and families at the point of intake.
- Because the single entry model provides for single assessment, duplication of professional effort is avoided, as is the associated stress on the client and family.

Under a single entry model, all Nursing Home applicants would be screened, assessed, waitlisted, and admitted to Nursing Homes according to provincial policies administered by authorities in the local communities. Private pay applicants would not be permitted to access the Nursing Home beds directly.

The single entry model would also provide the access point for other continuing care services such as home care. Through the "one stop shopping" concept, all Nursing Home applicants will be made aware of alternative service options. Only those applicants who have a demonstrated need will be considered for Nursing Home placement. Therefore, access to continuing care services is improved by ensuring applicants are aware of

available services, and system efficiency is improved through appropriate utilization of Nursing Homes.

Access through the single entry model could involve a broad or narrow range of continuing care services. For instance, it may be restricted to the continuing care services under the Department of Health such as home care and Nursing Homes or it may include some or all of the continuing care services that fall under the mandate of the Department of Community Services. Making the decision as to "single entry to what services?" is an important first step in implementing the model. Some provinces have chosen to create a single entry model to services that are predominately utilized by seniors (e.g. home care, Nursing Homes, and other community based services) whereas other provinces have included services to the younger disabled population such as group homes and other services for mentally challenged or post-mentally ill.

In the generic single entry model of continuing care, initial contact is made with a single organization representing the single access point. Access can be through a 1-800 number. During this contact, there is a screening process (intake) by which it is determined whether the need for an assessment is routine or urgent. A care coordinator is assigned and an initial visit is arranged, usually in the client's home or place of residence. If, during the assessment, it is determined that the potential client is not eligible for care or does not wish to receive care, other appropriate referrals are made and accompanying information provided. Referrals may also be made at the intake stage if it is clear that a complete assessment is not required. Using a comprehensive methodology, the assessment determines the client's needs, identifies personal, family, and community supports, and identifies the services required. Based on this assessment, the client is "placed", that is, a service plan is developed with the client and the family, negotiating with appropriate agencies and care providers to ensure the provision of all required services, and putting the plan into action. The service plan is monitored on an ongoing basis throughout the case management process to ensure that appropriate adjustments are made as the client's needs or circumstances change. **See Appendix 12 for a graphic illustration of the generic single entry model as described above.**

The single entry model has been introduced in every province in Canada (except Quebec and Nova Scotia) and some provinces have been developing the concept for over a decade. Although the overall guiding principles and major component do not vary considerably, each province has uniquely put the model into operation. The introduction of the single entry model across Canada has demonstrated how demand for facility based long term care services can be diverted to more appropriate community based alternatives. Two examples of this shift in service use can be drawn from New Brunswick and British Colombia.

A survey conducted in New Brunswick in 1989 indicated that 50 percent of those on the Nursing Home waiting lists could remain at home if the appropriate supports were available. Government responded by freezing the construction of new Nursing Home beds and by implementing the single entry model to both community and facility based long term care to seniors. Waiting lists for long term care beds dropped from 1050 in

1989 to between 50-80 in 1994. Waiting times were reduced from 1-2 years in some areas to no waiting time and empty beds in others. The province went from a projected need to build 300 beds in 1989 to a reduction of 141 beds by 1996. Also, hospital patients awaiting placement to long term care facilities dropped from 300 in 1989 to 50 in 1994 despite a reduction of 280 hospital beds in that same time period. Conversely, community based services had to be expanded to respond to the pressure of increasing numbers of seniors and increasing frailty (Daigle, 1996). New Brunswick found that not only was it possible to provide a broad range of long term care services to the elderly at a cost substantially below that of Nursing Homes, but that this care could be provided with a high level of satisfaction. According to Reamy (1996), a survey of both the elderly receiving services through the SEP and informal care givers found a 97% satisfaction level with the single entry process.

In the early 1980's, the British Columbia government was proactive in setting a policy to reallocate resources from facility based services to community based long term care services. They reduced their Nursing Home bed per 1000 population 65+ ratio by 20% over an eight year period. Conversely, they increased the number of clients receiving community based services per 1000 population 65+ ratio by 28% over the same period. Changes were possible in large part by introducing the single entry model including standardized assessment and case management and central control over waiting lists. (Hollander, 1994)

The single entry model could potentially introduce negative impacts if not carefully developed. For instance, prevailing market conditions and competition play a role in controlling the Nursing Home sector now i.e. Homes of relatively lower quality are motivated by vacant beds to upgrade. If the single entry system were to ensure vacancies are filled regardless of quality standards then it is conceivable that a decline in Nursing Homes service quality may result.

The Departments of Health and Community Services are developing an implementation plan for a single entry system of access that will streamline intake, assessment, placement, and case management functions for the clients and provide client access based on priority of identified needs.

b. Case Mix Classification System

The resources needed to meet the care needs of Nursing Home residents can vary widely, and our current system of funding does not sufficiently recognize the facility's case mix in the budget and per diem rate approval process. Under the current system of funding, a disincentive exists for Nursing Homes to accept applicants with higher care needs. Nursing Homes should be funded based on the assessed resource needs of their residents. To that end, a system of measurement and classification of the resource intensity of resident care needs is required to identify case mix measures for each facility.

Case mix provides funders with a system to equitably distribute limited resources. Facilities that care for clients with heavy care needs are provided more resources than facilities that care for clients with lighter needs. Case mix systems are not financing systems. The case mix does not specify the amount of funding needed in the sector. By way of analogy, case mix systems describe how the pie should be divided not how large the pie should be (Hirdes et al, 1999).

It has long been recognized that the current system of classifying Nursing Home residents in Nova Scotia is inadequate, especially for the purposes of allocating resources. In Nova Scotia, a Subcommittee of the Long Term Care Working Group attempted to develop a new assessment and classification system, but could not attain acceptable levels of validity and reliability. The Subcommittee recommended that Nova Scotia adopt a tool from another province that has already been proven to be valid and reliable.

The Resource Utilization Grouping (RUG-III) system represents the leading edge in case-mix classification systems for long term care facilities. In Canada, only one other case-mix classification system exists for long term care, i.e. the Alberta Resident Classification System. The ARCS is used in the Nursing Home and chronic care hospital sector of Alberta as well as in the Nursing Home sector of Ontario. However, given Alberta appears ready to abandon the ARCS in favor of a new RUG-III based classification system, the future use of ARCS is in serious doubt (Personal Communication, Alberta Health, 1999).

The RUG-III classification system has been developed to identify unique combinations of resident characteristics that result in differential patterns of resource utilization. It uses over 100 variables from the Resident Assessment Instrument (RAI 2.0) to produce 44 classification levels organized in 7 hierarchical domains.

For each of the 44 classification levels, a case mix index has been calculated through extensive time studies carried out in the USA and found to be valid and reliable through international studies including Canada. A case mix index represents the mean resources used by residents in that group relative to other groups. The time study data coupled with average salary information from nursing, rehabilitation, and auxiliary staff was used to develop the case mix indices (Fries et al, 1994).

Studies from Ontario and Saskatchewan have demonstrated that the RUG-III is a superior tool (JPPC, 1995) (Saskatchewan Health, 1999). Ontario has mandated the use of MDS 2.0 for assessment in its chronic care hospitals since 1996 and it is scheduled to begin using RUG-III for resource allocation commencing April 1, 2000. Since 1997 Saskatchewan has been piloting the MDS 2.0, and it has recently mandated that all 32 Health Districts must begin reporting RUG-III data by April 1, 2001. Other provinces are studying the tool. By April, 2000, the Nova Scotia Department of Health plans to commence testing the use of the Resident Assessment Instrument and RUG-III in 4 Nursing Homes to demonstrate its applicability in the Province.

c. Continuing Care System Planning

Nursing Home services are but one component of a wide array of continuing care services that respond to the health, social, and personal care needs of a long term nature. Continuing care services also includes home care, and other residential and community based services. In Nova Scotia, the Departments of Health and Community Services are accountable for the majority of publicly funded continuing care services. No structured and integrated mechanism exists between the departments to plan and manage these services. As a result, the maximization of existing resources, and the development of lower cost alternative services consistent with identified client needs is impeded.

Hollander (1994) identifies the existence of a single administrative structure to provide oversight to all aspects of continuing care services as a "best practice" in the administration of a continuing care system. He notes several positive aspects related to a single administrative structure:

- government funds can be more readily transferred between residential and community based services to maximize efficiencies
- maximizes the probability that policy issues will be viewed in the context of the total continuing care system
- maximizes the probability that care staff have a sense of the overall continuing care system, therefore, understand how the needs of the client can be best met within the system
- maximizes the probability that planning and resource allocation will be done on a systems basis, rather than on a component by component basis.

Determining the appropriate mix and levels of institutional, home and community based programs requires a system-wide approach to planning that relates to the overall policies of the province. Simply adding Nursing Home beds to relieve pressure on acute care beds may not be the most prudent response, especially if community based alternatives remain underdeveloped and the system of service delivery remains poorly structured.

A system wide approach to planning continuing care services is particularly needed in an era of an aging population. Statistics Canada (1997) projects that the "seniors" segment of Canada's population will grow from 12% in 1995 to 16% in 2016 and 23% by 2041. Given that 8% of seniors were living in an "institution" in 1991, the increase in seniors, both in absolute and proportional terms, will have a major impact on services for the aged including nursing homes. Partly in response to this shift in demographics, there is an international trend toward a declining focus on building institutions. People are only admitted to facilities when the costs of supporting them in their own homes become prohibitive (Alberta Health, 1999).

The Departments of Health and Community Services are currently discussing the possibilities for integration between the departments in the area of continuing care.

VI. Conclusion

Sufficient data is not available to determine the number of current Nursing Home residents who may have been more appropriately served in an alternative setting. An examination of the key elements of the Nursing Home system such as access, funding, and service planning suggest that system improvements could be made to better maximize our current supply of licensed Nursing Home beds.

Although hospitals report difficulties in discharging patients with continuing care needs, and demographers forecast an increasing elderly population, caution should be taken when planning the expansion of continuing care services such as Nursing Homes. As other provinces have experienced, these increasing pressures do not necessarily translate into a need for more Nursing Home beds.

Several provincial initiatives currently underway offer encouraging signs that system improvements in support of the right care in the right place as it relates to nursing homes may become reality.

VII. Recommendations

The Nursing Home Subgroup of the Health Facilities Review Team supports the following government planned initiatives:

a. The implementation of a single entry system of assessment, placement, and case management.

b. The testing of the Resident Assessment Instrument and its associated case mix classification system called the Resource Utilization Grouping system.

c. The integration of Department of Health and Department of Community Services programs as they relate to continuing care.

d. The investment in community based continuing care services such as adult day support and respite services.

The findings of this review suggest that the pursuit of such initiatives will begin to address key system deficiencies that must be overcome if continuing care services are to be appropriately configured and utilized.

The Subgroup further recommends the following:

- It is recommended that in the early stages of implementing single entry, government introduce a policy requiring all nursing home applicants be classified prior to admission. Concurrent with the introduction of this policy, government should

collaborate with the Nursing Home sector to develop a province-wide waitlist management policy and associated information system.

- It is recommended that the Department of Health begin to develop a Nursing Home financing system capable of utilizing the Resource Utilization Grouping system's case mix classification data.

- It is recommended that the Department of Health explore the development of continuing care services that are currently only partially available or not available. In addition to:

  - Adult Day Support and
  - Respite Services,

  the Department should consider:

  - Palliative Care;
  - Chronic Care Units/Hospitals;
  - (Geriatric)Assessment and Treatment Centers & Day Hospitals
  - Crisis Programs; and
  - Community Physiotherapy and Occupational Therapy.

  In pursuing the development of continuing care services, the Department should examine closely any available cost-effectiveness research, and commission its own research as needed.

- It is recommended that the Department of Health cautiously approach the expansion of "facility based" continuing care programs eg. Nursing Homes, and fully consider how the continuing care needs of the population may be met through alternative continuing care programs. In addition to strengthening "home based" services, the Department should work with other government departments to enhance the system's capacity to offer "supportive housing" service options to fill the gap between independent living and facility care.

- It is recommended that the Department of Health develop "Bed Planning Guidelines" for the allocation of new licensed nursing home beds. The work of the now disbanded Long Term Care Working Group's Subgroup on Bed Planning Guidelines should be consulted.

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APPENDICES

Licensed Beds

02/02/2000

Region	County	Home	Regular Beds	Respite
c	Halifax	Armview Estates	255	0
c	Halifax	Birches	40	2
c	Halifax	Duncan MacMillan	25	1
c	Halifax	Fairview Villa	207	2
c	Halifax	Glades	123	1
c	Halifax	Melville Lodge	120	4
c	Halifax	Musquodoboit Valley	28	1
c	Halifax	Northwood Care	538	15
c	Halifax	Oakwood Terrace	111	0
c	Halifax	Ocean View Manor	184	0
c	Halifax	Saint Vincent's	160	0
c	Halifax	Scotia Nursing	45	1
c	Hants	Dykeland	110	1
c	Hants	Haliburton Place	30	2
c	Hants	Windsor Elms	116	1
e	Antigonish	R K MacDonald	106	3
e	Cape Breton	Breton Bay	264	0
e	Cape Breton	Cove	108	2
e	Cape Breton	Glace Bay Health Centre	24	0
e	Cape Breton	Inverary Manor	60	0
e	Cape Breton	MacGillivary	74	2
e	Cape Breton	Maple Hill	50	0
e	Cape Breton	Miner's Memorial	35	2
e	Cape Breton	New Waterford	20	1
e	Cape Breton	Northside Guest Home	90	0
e	Cape Breton	Northside Harbour View	21	0
e	Cape Breton	Seaview Manor	101	2
e	Cape Breton	Victoria Haven	45	0
e	Guysborough	Canso	15	0
e	Guysborough	MacKarchers	39	0
e	Guysborough	Milford Haven	50	1
e	Inverness	Foyer Pere Fiset	60	0
e	Inverness	Inverness Memorial	11	0
e	Inverness	Port Hawkesbury	50	4
e	Richmond	Richmond Villa	75	0
e	Richmond	St. Anne's	24	0
e	Victoria	Alderwood Manor	70	0
e	Victoria	Highland Manor	20	0
n	Colchester	Glenview Lodge	48	0

Region	County	Home	Regular Beds	Respite
n	Colchester	Hillcrest Manor	119	0
n	Colchester	Willow Lodge	51	0
n	Cumberland	Bayview Memorial	8	2
n	Cumberland	East Cumberland Lodge	65	0
n	Cumberland	Gables	95	4
n	Cumberland	High-Crest Springhill	45	1
n	Cumberland	South Cumberland Hospital	14	0
n	Pictou	Glen Haven	212	0
n	Pictou	Maritime Oddfellows	44	3
n	Pictou	Shiretown	94	0
n	Pictou	Valley View Villa	109	4
w	Annapolis	Annapolis Royal	44	0
w	Annapolis	Mountain Lea Lodge	112	1
w	Annapolis	Northhills	48	1
w	Digby	Tideview Terrace	89	1
w	Digby	Villa Acadienne	84	2
w	Kings	Evergreen Home	97	0
w	Kings	Grandview Manor	118	0
w	Kings	Wolfville	66	0
w	Lunenburg	Harbour View Haven	129	1
w	Lunenburg	Hillside Pines	50	0
w	Lunenburg	Mahone Bay	57	4
w	Lunenburg	Rosedale Home	29	0
w	Lunenburg	Shoreham Village	83	1
w	Queen's	North Queens	42	2
w	Queen's	Queen's Manor	60	1
w	Shelburne	Roseway Manor	65	1
w	Shelburne	Surf Lodge	34	2
w	Yarmouth	Nakile Home	35	1
w	Yarmouth	Tidal View Manor	103	2
w	Yarmouth	Villa St Joseph du Lac	79	0
		Grand Total:	**5,832**	**82**

Source:

1. Directory Nursing Homes and Homes for the Aged Long Term Care -June 1999

Nursing Home Beds per 1000 Population 75 years and older AND
Residential Care Facilities (with a seniors population) per 1000 Population 75 years and older

Region	County	Population [1] 75 plus	Nursing Homes [2] Beds	Ratio	Residential Care Facilities [3] Beds	Ratio	Combined Ratio
c	Halifax	16,701	1,836	109.9	24	1.4	111.4
c	Hants	2,273	256	112.6	22	9.7	122.3
e	Antigonish	1,274	106	83.2	0	0.0	83.2
e	Cape Breton	7,921	832	105.0	7	0.9	105.9
e	Guysborough	809	104	128.6	0	0.0	128.6
e	Inverness	1,435	181	126.1	22	15.3	141.5
e	Richmond	898	99	110.2	0	0.0	110.2
e	Victoria	575	90	156.5	0	0.0	156.5
n	Colchester	3,336	218	65.3	134	40.2	105.5
n	Cumberland	2,930	227	77.5	150	51.2	128.7
n	Pictou	3,784	456	120.5	79	20.9	141.4
w	Annapolis	1,977	207	104.7	53	26.8	131.5
w	Digby	1,893	173	91.4	47	24.8	116.2
w	Kings	3,565	281	78.8	49	13.7	92.6
w	Lunenburg	3,709	348	93.8	43	11.6	105.4
w	Queens	1,065	102	95.8	0	0.0	95.8
w	Shelburne	1,165	99	85.0	18	15.5	100.4
w	Yarmouth	2,322	217	93.5	37	15.9	109.4
	Grand Total:	57,632	5,832	101.1	685	11.8	113.0

1. Statistics Canada Demographic Division-Population Estimates for 1998
2. Directory Nursing Homes and Homes for the Aged Long Term Care - June 1999
3. Department of Community Services "RCF's with a Senior's Population" fax communication May, 1999

Annual Occupancy Rates

08/02/2000

Region	County	Facility	Beds	Occupancy
c	Halifax	Armview Estates	255	99.6
c	Halifax	Birches	40	100.0
c	Halifax	Duncan MacMillan	25	99.0
c	Halifax	Fairview Villa	207	98.8
c	Halifax	Glades	123	99.0
c	Halifax	Melville Lodge	120	100.0
c	Halifax	Musquodoboit Valley	28	99.3
c	Halifax	Northwood Care	538	90.0
c	Halifax	Oakwood Terrace	111	99.2
c	Halifax	Oceanview Manor	184	99.0
c	Halifax	Saint Vincent's	160	100.0
c	Halifax	Scotia Nursing	45	100.0
c	Hants	Dykeland	110	99.8
c	Hants	Haliburton Place	30	97.9
c	Hants	Windsor Elms	116	99.9
e	Antigonish	R.K. MacDonald	106	99.7
e	Cape Breton	Breton Bay	264	99.4
e	Cape Breton	Cove	108	99.0
e	Cape Breton	Glace Bay Health Centre	24	98.2
e	Cape Breton	Inverary Manor	60	99.5
e	Cape Breton	MacGillivary	74	99.5
e	Cape Breton	Maple Hill	50	99.9
e	Cape Breton	Miner's Memorial	35	99.9
e	Cape Breton	Northside Guest Home	90	99.9
e	Cape Breton	Northside Harbour View	21	97.9
e	Cape Breton	Seaview Manor	101	99.0
e	Cape Breton	Victoria Haven	45	99.9
e	Guysborough	Canso	15	100.0
e	Guysborough	MacKarchers	39	99.8
e	Guysborough	Milford Haven	50	99.8
e	Inverness	Foyer Pere Fiset	60	99.9
e	Inverness	Inverness Memorial	11	100.0
e	Inverness	Port Hawkesbury	50	100.0
e	Richmond	Richmond Villa	75	98.6
e	Richmond	St. Anne's	24	99.1

Region	County	Facility	Beds	Occupancy
e	Victoria	Alderwood Manor	70	99.9
e	Victoria	Highland Manor	20	99.9
n	Colchester	Glenview Lodge	48	99.0
n	Colchester	Hillcrest Manor	119	99.6
n	Colchester	Willow Lodge	51	99.0
n	Cumberland	Bayview Memorial	8	96.0
n	Cumberland	East Cumberland Lodge	65	97.0
n	Cumberland	Gables	95	99.9
n	Cumberland	High-Crest Springhill	45	100.7
n	Cumberland	South Cumberland Hospital	14	99.2
n	Pictou	Glen Haven	212	99.6
n	Pictou	Maritime Oddfellows	44	100.0
n	Pictou	Shiretown	94	99.5
n	Pictou	Valley View Villa	109	99.8
w	Annapolis	Annapolis Royal	44	99.7
w	Annapolis	Northhills	48	91.0
w	Digby	Tideview Terrace	89	100.0
w	Digby	Villa Acadienne	84	100.0
w	Kings	Evergreen Home	97	99.0
w	Kings	Grandview Manor	118	99.7
w	Kings	Wolfville	66	99.0
w	Lunenburg	Harbour View Haven	129	98.9
w	Lunenburg	Rosedale Home	29	99.6
w	Lunenburg	Shoreham Village	83	99.3
w	Queen's	North Queens	42	100.0
w	Queen's	Queen's Manor	60	99.4
w	Shelburne	Roseway Manor	65	99.3
w	Shelburne	Surf Lodge	34	99.5
w	Yarmouth	Tidal View Manor	103	99.8
w	Yarmouth	Villa St Joseph du Lac	79	99.8
		Average		**99.1**

Source:

1. Department of Health Licensing Report for Nursing Homes and Homes for the Aged- October22, 1998 to December 2, 1999
(65 Homes reporting)

Annual Turnover Rates of Nursing Home Residents

Region	County	Facility	Beds	%Turnover[2]	% Turnover Adjusted
c	Halifax	Armview Estates	255	49.0	38.0
c	Halifax	Birches	40	22.5	22.5
c	Halifax	Duncan MacMillan	25	28.0	28.0
c	Halifax	Glades	123	46.3	40.7
c	Halifax	Melville Lodge	120	54.1	52.5
c	Halifax	Musquodoboit Valley	28	39.2	39.3
c	Halifax	Northwood Care	538	30.1	30.1
c	Halifax	Oakwood Terrace	111	27.0	27.0
c	Halifax	Oceanview Manor	184	40.7	40.8
c	Halifax	Saint Vincent's	160	26.2	25.6
c	Halifax	Scotia Nursing	45	28.8	28.9
c	Halifax	Fairview Villa	207	34.3	34.3
c	Hants	Dykeland	110	36.3	36.4
c	Hants	Haliburton Place	30	56.6	50.0
c	Hants	Windsor Elms	116	33.6	31.9
e	Antigonish	R.K. MacDonald	106	33.0	33.0
e	Cape Breton	Breton Bay	264	45.4	39.0
e	Cape Breton	Cove	108	25.9	25.9
e	Cape Breton	Glace Bay Health Centre	24	79.1	79.2
e	Cape Breton	Inverary Manor	60	18.3	18.3
e	Cape Breton	MacGillivary	74	32.4	32.4
e	Cape Breton	Maple Hill	50	10.0	10.0
e	Cape Breton	Miner's Memorial	35	11.4	11.4
e	Cape Breton	Northside Guest Home	90	23.3	22.2
e	Cape Breton	Northside Harbour View	21	23.8	19.0
e	Cape Breton	Seaview Manor	101	18.8	17.8
e	Cape Breton	Victoria Haven	45	13.3	11.1
e	Cape Breton	New Waterford	20	10.0	0.0
e	Guysborough	Canso	15	60.0	46.7
e	Guysborough	MacKarchers	39	35.9	30.8
e	Guysborough	Milford Haven	50	52.0	36.0
e	Inverness	Foyer Pere Fiset	60	23.3	23.3
e	Inverness	Inverness Memorial	11	27.2	18.2
e	Inverness	Port Hawkesbury	50	18.0	18.0
e	Richmond	Richmond Villa	75	40.0	32.0
e	Richmond	St. Anne's	24	25.0	25.0
e	Victoria	Alderwood Manor	70	20.0	12.9
e	Victoria	Highland Manor	20	15.0	15.0
n	Colchester	Glenview Lodge	48	35.4	35.4
n	Colchester	Hillcrest Manor	119	33.6	30.3
n	Colchester	Willow Lodge	51	23.5	23.5
n	Cumberland	Bayview Memorial	8	37.5	37.5
n	Cumberland	East Cumberland Lodge	65	40.0	35.4
n	Cumberland	Gables	95	46.3	36.8

Region	County	Facility	Beds	%Turnover [2]	% Turnover Adjusted [3]
n	Cumberland	High-Crest Springhill	45	31.1	31.1
n	Cumberland	South Cumberland Hospital	14	57.1	57.1
n	Pictou	Glen Haven	212	33.9	32.1
n	Pictou	Maritime Oddfellows	44	11.3	11.4
n	Pictou	Shiretown	94	15.9	13.8
n	Pictou	Valley View Villa	109	19.2	19.3
w	Annapolis	Annapolis Royal	44	29.5	20.5
w	Annapolis	Mountain Lea Lodge	112	36.6	36.6
w	Annapolis	Northhills	48	116.6	66.7
w	Digby	Tideview Terrace	89	42.7	42.7
w	Digby	Villa Acadienne	84	35.7	34.5
w	Kings	Evergreen Home	97	43.3	43.3
w	Kings	Grandview Manor	118	33.9	32.2
w	Kings	Wolfville	66	50.0	30.3
w	Lunenburg	Harbour View Haven	129	37.9	34.1
w	Lunenburg	Hillside Pines	50	44.0	40.0
w	Lunenburg	Mahone Bay	57	36.8	28.1
w	Lunenburg	Rosedale Home	29	48.2	48.3
w	Lunenburg	Shoreham Village	83	32.5	32.5
w	Queen's	North Queens	42	19.0	19.0
w	Queen's	Queen's Manor	60	25.0	25.0
w	Shelburne	Roseway Manor	65	20.0	20.0
w	Shelburne	Surf Lodge	34	29.4	17.6
w	Yarmouth	Nakile Home	35	5.7	5.7
w	Yarmouth	Tidal View Manor	103	33.0	31.1
w	Yarmouth	Villa St Joseph du Lac	79	31.6	27.8
		Grand Total:	5,832	34.2	31.3

Source:

1. Department of Health Licensing Report for Nursing Homes and Homes for the Aged- October 22, 1998 to December 2, 1999
2. Turnover = (admissions/beds*100%)
3. Turnover adjusted = (admissions-interfacility transfers) / beds *100%

Age and Sex [1]

01/02/2000

Region	County	Facility	% Over 65	% Female	Average Age
c	Halifax	Armview Estates	80.0	73.7	76
c	Halifax	Birches	100.0	82.0	87
c	Halifax	Duncan MacMillan	96.0	56.0	86
c	Hants	Dykeland	100.0	77.2	85
c	Halifax	Glades	92.6	61.7	79
c	Hants	Haliburton Place	86.6	43.3	79
c	Halifax	Melville Lodge	96.6	80.6	87
c	Halifax	Musquodoboit Valley	96.4	64.2	87
n	Halifax	Northwood Care	96.6	79.0	84
c	Halifax	Oakwood Terrace	100.0	82.3	84
c	Halifax	Ocean View Manor	93.9	75.8	82
c	Halifax	Saint Vincent's	100.0	85.6	89
c	Halifax	Scotia Nursing	78.2	60.8	72
c	Halifax	Fairview Villa	90.9	75.6	86
c	Hants	Windsor Elms	97.3	77.1	86
e	Victoria	Alderwood Manor	95.7	71.4	82
e	Cape Breton	Breton Bay	87.3	62.3	79
e	Guysborough	Canso	93.3	80.0	80
e	Cape Breton	Cove	98.1	86.1	83
e	Inverness	Foyer Pere Fiset	100.0	68.3	83
e	Cape Breton	Glace Bay Health Centre	94.0	42.0	80
e	Victoria	Highland Manor	90.0	65.0	81
e	Inverness	Inverness Memorial	90.9	54.5	88
e	Cape Breton	Inverary Manor	95.0	83.3	85
e	Cape Breton	MacGillivary	98.6	77.0	82
e	Guysborough	MacKarchers	89.7	79.4	81
e	Cape Breton	Maple Hill	96.0	84.0	83
e	Guysborough	Milford Haven	92.0	68.0	83
e	Cape Breton	Miner's Memorial	100.0	85.2	83
e	Cape Breton	Northside Guest Home	96.6	80.0	84
e	Cape Breton	Northside Harbour View	71.4	66.6	75
e	Inverness	Port Hawkesbury	94.0	72.0	84
e	Antigonish	R.K. MacDonald	91.5	71.7	81
e	Richmond	Richmond Villa	92.0	68.0	82
e	Cape Breton	Seaview Manor	93.0	89.0	86
e	Richmond	St. Anne's	91.6	75.0	85

Region	County	Facility	% Over 65	% Female	Average Age
e	Cape Breton	Victoria Haven	82.2	75.5	77
n	Cumberland	Bayview Memorial	100.0	37.5	85
n	Cumberland	East Cumberland Lodge	100.0	70.0	85
n	Cumberland	Gables	88.4	67.3	79
n	Pictou	Glen Haven	96.6	76.1	85
n	Colchester	Glenview Lodge	91.6	75.0	84
n	Cumberland	High-Crest Springhill	91.1	82.2	81
n	Colchester	Hillcrest Manor	91.4	69.2	80
n	Pictou	Maritime Oddfellows	98.1	83.0	88
n	Pictou	Shiretown	97.8	85.1	85
n	Cumberland	South Cumberland Hospital	100.0	71.4	85
n	Pictou	Valley View Villa	98.5	56.8	83
n	Colchester	Willow Lodge	95.9	73.4	82
w	Annapolis	Annapolis Royal	93.1	79.5	84
w	Kings	Evergreen Home	86.6	72.1	81
w	Kings	Grandview Manor	96.5	72.6	84
w	Lunenburg	Harbour View Haven	99.2	78.9	86
w	Lunenburg	Hillside Pines	96.0	72.0	84
w	Lunenburg	Mahone Bay	94.6	76.7	82
w	Annapolis	Mountain Lea Lodge	93.6	70.9	84
w	Yarmouth	Nakile Home	100.0	88.5	86
w	Queen's	North Queens	95.4	81.8	86
w	Annapolis	Northhills	95.2	83.3	84
w	Queen's	Queen's Manor	93.2	72.8	84
w	Lunenburg	Rosedale Home	100.0	72.4	86
w	Shelburne	Roseway Manor	93.8	73.8	82
w	Lunenburg	Shoreham Village	100.0	77.1	84
w	Shelburne	Surf Lodge	100.0	66.6	84
w	Yarmouth	Tidal View Manor	95.1	73.7	84
w	Digby	Tideview Terrace	93.1	79.5	86
w	Digby	Villa Acadienne	94.0	71.4	83
w	Yarmouth	Villa St Joseph du Lac	93.6	77.2	85
w	Kings	Wolfville	98.3	86.8	86
e	Cape Breton	New Waterford	80.9	66.6	79
		Average	**94.0**	**73.1**	**83**

Source:

1. Department of Health Licensing Report for Nursing Homes and Homes for the Aged-October 22, 1998 to December 2, 1999

% of Residents with Type 2 Care Needs

Region	County	Home	% Type 2	% Type 2 Adjusted (2)
c	Halifax	Armview Estates	94.1	94.1
c	Halifax	Birches	69.0	69.0
c	Halifax	Duncan MacMillan	56.0	56.0
c	Halifax	Fairview Villa	98.6	98.6
c	Halifax	Glades	86.2	86.2
c	Halifax	Melville Lodge	93.3	93.3
c	Halifax	Musquodoboit Valley	89.3	89.3
c	Halifax	Northwood Care	66.0	98.9
c	Halifax	Oakwood Terrace	86.5	86.5
c	Halifax	Ocean View Manor	73.1	73.1
c	Halifax	Saint Vincent's	67.5	80.6
c	Halifax	Scotia Nursing	76.1	76.1
c	Hants	Dykeland	84.5	84.5
c	Hants	Haliburton Place	90.0	90.0
c	Hants	Windsor Elms	50.4	50.4
e	Antigonish	R.K. MacDonald	97.2	97.2
e	Cape Breton	Breton Bay	94.4	94.4
e	Cape Breton	Cove	79.6	79.6
e	Cape Breton	Glace Bay Health Centre	87.5	87.5
e	Cape Breton	Inverary Manor	85.0	85.0
e	Cape Breton	MacGillivary	95.9	95.9
e	Cape Breton	Maple Hill	96.0	96.0
e	Cape Breton	Miner's Memorial	57.1	57.1
e	Cape Breton	New Waterford	100.0	100.0
e	Cape Breton	Northside Guest Home	75.6	75.6
e	Cape Breton	Northside Harbour View	100.0	100.0
e	Cape Breton	Seaview Manor	94.1	100.0
e	Cape Breton	Victoria Haven	75.6	100.0
e	Guysborough	Canso	100.0	100.0
e	Guysborough	MacKarchers	94.9	94.9
e	Guysborough	Milford Haven	94.0	94.0
e	Inverness	Foyer Pere Fiset	88.3	88.3
e	Inverness	Inverness Memorial	100.0	100.0
e	Inverness	Port Hawkesbury	88.0	88.0
e	Richmond	Richmond Villa	87.7	87.7
e	Richmond	St. Anne's	79.2	79.2
e	Victoria	Alderwood Manor	80.0	80.0
e	Victoria	Highland Manor	85.0	85.0
n	Colchester	Glenview Lodge	100.0	100.0
n	Colchester	Hillcrest Manor	100.0	100.0
n	Colchester	Willow Lodge	96.1	96.1
n	Cumberland	Bayview Memorial	100.0	100.0
n	Cumberland	East Cumberland Lodge	94.9	94.9
n	Cumberland	Gables	96.8	96.8

Region	County	Home	% Type 2	% Type 2 Adjusted (2)
n	Cumberland	High-Crest Springhill	100.0	100.0
n	Cumberland	South Cumberland Hospital	100.0	100.0
n	Pictou	Glen Haven	94.3	94.3
n	Pictou	Maritime Oddfellows	77.3	77.3
n	Pictou	Shiretown	73.4	89.6
n	Pictou	Valley View Villa	70.6	70.6
w	Annapolis	Annapolis Royal	97.7	97.7
w	Annapolis	Mountain Lea Lodge	75.5	75.5
w	Annapolis	Northhills	87.5	87.5
w	Digby	Tideview Terrace	97.8	97.8
w	Digby	Villa Acadienne	88.8	88.8
w	Kings	Evergreen Home	86.6	86.6
w	Kings	Grandview Manor	92.3	92.3
w	Kings	Wolfville	89.4	89.4
w	Lunenburg	Harbour View Haven	66.4	66.4
w	Lunenburg	Hillside Pines	84.0	84.0
w	Lunenburg	Mahone Bay	93.0	93.0
w	Lunenburg	Rosedale Home	96.6	96.6
w	Lunenburg	Shoreham Village	64.6	64.6
w	Queen's	North Queens	81.8	81.8
w	Queen's	Queen's Manor	80.0	80.0
w	Shelburne	Rosaway Manor	73.8	73.8
w	Shelburne	Surf Lodge	100.0	100.0
w	Yarmouth	Nakile Home	62.9	62.9
w	Yarmouth	Tidal View Manor	76.7	76.7
w	Yarmouth	Villa St Joseph du Lac	97.5	97.5
		Average	**83.8**	**87.3**

Source:

1. **Department of Health Licensing Report for Nursing Homes and Homes for the Aged- October 22, 1998 to December 2, 1999**
2. **This column shows the % of Type 2 residents after the designated Type 1 care beds have been removed. Because of fire safety concerns, five homes have beds designated for the exclusive use of residents with Type 1 care needs.**
   These are Northwood Manor (175 beds), Seaview Manor (920 beds), Victoria Haven (16) beds, St. Vincent's Guest Home (26 beds) and Shiretown (17 beds).

% Dementias (diagnosed and undiagnosed)

1/02/2000

Region	County	Facility	Diagnosed	Undiagnosed	Total
c	Halifax	Armview Estates	40.3	6.6	47.0
c	Halifax	Birches	45.0	2.5	47.5
c	Halifax	Duncan MacMillan	12.0	0.0	12.0
c	Halifax	Fairview Villa	48.3	21.2	69.5
c	Halifax	Glades	43.0	13.8	56.9
c	Halifax	Melville Lodge	40.8	1.6	42.5
c	Halifax	Musquodoboit Valley	46.4	14.2	60.7
c	Halifax	Northwood Care	31.2	13.2	44.4
c	Halifax	Oakwood Terrace	53.1	9.9	63.0
c	Halifax	Ocean View Manor	28.8	1.0	29.8
c	Halifax	Saint Vincent's	35.0	31.2	66.2
c	Halifax	Scotia Nursing	35.5	28.8	64.4
c	Hants	Dykeland	40.0	17.2	57.2
c	Hants	Haliburton Place	16.6	23.3	40.0
e	Antigonish	R.K. MacDonald	29.2	0.0	29.2
e	Cape Breton	Breton Bay	36.3	4.9	41.2
e	Cape Breton	Cove	30.5	12.9	43.5
e	Cape Breton	Glace Bay Health Centre	54.1	8.3	62.5
e	Cape Breton	Inverary Manor	35.0	8.3	43.3
e	Cape Breton	MacGillivary	25.6	22.9	48.6
e	Cape Breton	Maple Hill	46.0	2.0	48.0
e	Cape Breton	Miner's Memorial	28.5	17.1	45.7
e	Cape Breton	New Waterford	30.0	30.0	60.0
e	Cape Breton	Northside Guest Home	37.7	8.8	46.6
e	Cape Breton	Northside Harbour View	14.2	9.5	23.8
e	Cape Breton	Seaview Manor	58.4	5.9	64.3
e	Cape Breton	Victoria Haven	60.0	20.0	80.0
e	Guysborough	Canso	46.6	0.0	46.6
e	Guysborough	MacKarchers	53.8	2.5	56.4
e	Guysborough	Milford Haven	46.0	14.0	60.0
e	Inverness	Foyer Pere Fiset	45.0	0.0	45.0
e	Inverness	Inverness Memorial	27.2	9.0	36.3
e	Inverness	Port Hawkesbury	48.0	4.0	52.0
e	Richmond	Richmond Villa	48.0	13.3	61.3
e	Richmond	St. Anne's	29.1	0.0	29.1

Region	County	Facility	Diagnosed	Undiagnosed	Total
e	Victoria	Alderwood Manor	35.7	14.2	50.0
e	Victoria	Highland Manor	45.0	35.0	80.0
n	Colchester	Glenview Lodge	27.0	0.0	27.0
n	Colchester	Hillcrest Manor	45.3	4.2	49.5
n	Colchester	Willow Lodge	11.7	9.8	21.5
n	Cumberland	Bayview Memorial	62.5	0.0	62.5
n	Cumberland	East Cumberland Lodge	41.5	7.6	49.2
n	Cumberland	Gables	48.4	3.1	51.5
n	Cumberland	High-Crest Springhill	57.7	6.6	64.4
n	Cumberland	South Cumberland Hospital	42.8	21.4	64.2
n	Pictou	Glen Haven	50.4	13.6	64.1
n	Pictou	Maritime Oddfellows	54.5	18.1	72.7
n	Pictou	Shiretown	22.3	41.4	63.8
n	Pictou	Valley View Villa	35.7	15.6	51.3
w	Annapolis	Annapolis Royal	40.9	31.8	72.7
w	Annapolis	Mountain Lea Lodge	22.3	3.5	25.8
w	Annapolis	Northhills	39.5	18.7	58.3
w	Digby	Tideview Terrace	31.4	11.2	42.7
w	Digby	Villa Acadienne	41.3	55.9	97.6
w	Hants	Windsor Elms	41.3	20.6	62.0
w	Kings	Evergreen Home	35.0	20.6	55.6
w	Kings	Grandview Manor	33.9	6.7	40.6
w	Kings	Wolfville	60.6	4.5	65.1
w	Lunenburg	Harbour View Haven	30.2	13.1	43.4
w	Lunenburg	Hillside Pines	24.0	22.0	46.0
w	Lunenburg	Mahone Bay	22.8	7.0	29.8
w	Lunenburg	Rosedale Home	44.8	3.4	48.2
w	Lunenburg	Shoreham Village	39.7	8.4	48.1
w	Queen's	North Queens	26.1	9.5	35.7
w	Queen's	Queen's Manor	21.6	20.0	41.6
w	Shelburne	Roseway Manor	38.4	7.6	46.1
w	Shelburne	Surf Lodge	32.3	32.3	64.7
w	Yarmouth	Nakile Home	5.7	20.0	25.7
w	Yarmouth	Tidal View Manor	20.3	10.6	31.0
w	Yarmouth	Villa St Joseph du Lac	51.9	6.3	58.2
		Average	**37.5**	**12.6**	**50.2**

Source:

1. Department of Health Licensing Report for Nursing Homes and Homes for the Aged- October 22, 1998 to December 2, 1999

% of Residents with Select Late-Loss Activities of Daily Living

08/02/2000

Region	County	Facility	Mobility (2)	Toiletting (3)	Eating (4)
c	Halifax	Oakwood Terrace	66.7	68.5	45.0
c	Halifax	Ocean View Manor	68.1	58.2	30.6
c	Halifax	Scotia Nursing	56.5	0.0	33.3
c	Halifax	Birches	30.8	50.0	34.3
c	Halifax	Armview Estates	71.1	64.3	33.6
c	Halifax	Duncan MacMillan	50.0	28.0	20.7
c	Halifax	Fairview Villa	73.7	72.0	37.3
c	Halifax	Glades	52.5	33.3	51.2
c	Halifax	Musquodoboit Valley	64.3	50.0	21.4
c	Halifax	Saint Vincent's	52.9	73.1	64.0
c	Halifax	Melville Lodge	75.8	57.5	81.3
c	Halifax	Northwood Care	41.7	45.5	12.4
c	Hants	Windsor Elms	38.5	56.0	54.3
c	Hants	Dykeland	68.2	71.8	34.5
c	Hants	Haliburton Place	70.0	56.7	40.7
e	Antigonish	R.K. MacDonald	68.3	57.5	43.4
e	Cape Breton	Breton Bay	45.6	62.9	68.2
e	Cape Breton	Cove	34.9	50.0	39.4
e	Cape Breton	MacGillivary	59.5	47.3	67.6
e	Cape Breton	Maple Hill	66.0	0.0	60.0
e	Cape Breton	Miner's Memorial	87.5	54.3	25.7
e	Cape Breton	New Waterford	84.2	75.0	65.0
e	Cape Breton	Northside Guest Home	57.8	54.4	30.0
e	Cape Breton	Northside Harbour View	66.7	38.1	28.6
e	Cape Breton	Seaview Manor	60.4	52.5	38.0
e	Cape Breton	Glace Bay Health Centre	70.0	62.5	61.1
e	Cape Breton	Victoria Haven	33.3	55.6	42.2
e	Guysborough	Milford Haven	44.0	62.0	34.0
e	Guysborough	Canso	66.7	73.3	46.7
e	Guysborough	MacKarchers	43.6	59.0	31.6
e	Inverness	Foyer Pere Fiset	48.3	0.0	26.7
e	Inverness	Inverness Memorial	72.7	0.0	27.3
e	Inverness	Inverary Manor	59.0	53.3	43.5
e	Inverness	Port Hawkesbury	68.0	52.0	40.7
e	Richmond	Richmond Villa	53.3	0.0	40.5
e	Richmond	St. Anne's	75.0	50.0	33.3
e	Victoria	Alderwood Manor	58.6	54.3	28.6
e	Victoria	Highland Manor	55.0	75.0	35.0
n	Colchester	Glenview Lodge	72.9	37.5	52.1
n	Colchester	Hillcrest Manor	69.6	82.4	71.9
n	Colchester	Willow Lodge	54.3	41.2	43.1
n	Cumberland	High-Crest Springhill	66.7	48.9	44.4

Region	County	Facility	Mobility (2)	Toiletting (3)	Eating (4)
n	Cumberland	Bayview Memorial	83.3	75.0	75.0
n	Cumberland	East Cumberland Lodge	64.4	58.5	28.6
n	Cumberland	South Cumberland Hospital	42.9	57.1	46.2
n	Cumberland	Gables	63.9	52.6	64.1
n	Pictou	Maritime Oddfellows	50.0	50.0	39.5
n	Pictou	Shiretown	55.3	70.2	37.2
n	Pictou	Valley View Villa	60.6	52.3	43.2
n	Pictou	Glen Haven	69.5	67.0	58.7
w	Annapolis	Mountain Lea Lodge	67.9	55.4	48.6
w	Annapolis	Northhills	57.4	70.8	28.9
w	Annapolis	Annapolis Royal	81.8	54.5	63.6
w	Digby	Tideview Terrace	57.5	40.4	26.2
w	Digby	Villa Acadienne	67.4	57.1	36.5
w	Kings	Evergreen Home	54.9	51.5	40.6
w	Kings	Grandview Manor	71.6	77.1	62.6
w	Kings	Wolfville	59.1	65.2	50.0
w	Lunenburg	Hillside Pines	75.0	74.0	28.6
w	Lunenburg	Mahone Bay	63.5	70.2	36.1
w	Lunenburg	Rosedale Home	67.9	0.0	21.6
w	Lunenburg	Shoreham Village	58.5	62.7	37.1
w	Lunenburg	Harbour View Haven	56.9	74.4	34.2
w	Queen's	North Queens	52.3	71.4	23.3
w	Queen's	Queen's Manor	65.5	50.0	31.0
w	Shelburne	Roseway Manor	69.2	58.5	37.5
w	Shelburne	Surf Lodge	63.9	58.8	14.7
w	Yarmouth	Nakile Home	55.9	62.9	75.0
w	Yarmouth	Tidal View Manor	58.2	57.3	39.8
w	Yarmouth	Villa St Joseph du Lac	63.5	60.8	52.7
		Average	**59.4**	**58.9**	**42.6**

Source:

1. **Department of Health Licensing Report for Nursing Homes and Homes for the Aged- October 22, 1998 to December 2, 1999.**
2. **This column shows the % of residents who require staff assistance to mobilize and/ or transfer.**
3. **This column shows the % of residents who utilize reusable/disposable incontinent systems. (Non reporting homes have been removed from the average)**
4. **This column shows the % of residents who need to be fed or can feed themselves under constant supervision.**

Nursing Home Approved Per Diem Rates

Appendix 9

Home	Approved Per Diem October 1, 1999	Comments
Alte Curam	109.45	
Alderwood Manor	101.58	Light = 83.11
Annapolis Royal Nursing Home	92.57	
Armview Estates	109.60	
Bayview Memorial Health Centre	90.00	
The Birches	109.73	
Breton Bay Nursing Home	110.79	
Canso-Seaside Manor	122.19	
Duncan MacMillan Home	119.05	
Dykeland Lodge	93.59	
East Cumberland Lodge	104.83	
Evergreen Home	106.85	Children = 177.79
Fairview Villa	109.60	
Foyer Pere Fiset	91.37	Light = 74.76
Gables Nursing Home	97.57	
Glades Lodge	101.02	
Glen Haven Manor	86.15	
Glenview Lodge	96.67	
Grand View Manor	94.07	
Haliburton Place	112.39	
Harbour View Haven	90.05	
High-Crest Sherbrooke	88.59	
High-Crest Springhill	113.52	
Hillcrest Manor	116.54	
Hillside Pines	97.88	
Highland Manor	147.21	
Inverary Manor	103.16	Light = 84.40
MacGillivray Guest Home	110.34	Light = 90.29
High-Crest Sherbrooke	93.43	
Mahone Nursing Home	104.26	
Maple Hill Manor	112.90	
Maritime Odd Fellows Home	107.88	
Melville Lodge	106.16	
Milford Haven	106.48	
Miner's Memorial Manor	117.69	
Mountain Lea Lodge	85.77	
Musquodoboit Valley	114.84	
Nakile Home for the Aged	109.36	
Northhills Nursing Home	96.31	
North Queens Nursing Home	122.26	
Northside Guest Home	104.13	
Northside Level II	101.00	
Northwoodcare Incorporated	122.77	PC = 100.45 SC = 68.35
Oakwood Terrace	105.36	
Oceanview Manor	99.80	
Port Hawkesbury Nursing Home	114.80	
Queens Manor	96.76	
R.K. MacDonald Nursing Home	115.40	Light = 94.89
Richmond Villa	91.21	
Rosedale Home for Special Care	109.48	
Roseway Manor Inc.	102.62	
Saint Vincent's Guest Home	110.83	Light = 90.88
Seaview Manor	114.94	
Scotia Nursing Home	113.10	
Shiretown Nursing Home	111.34	Light = 91.10 Resident = 66.85
Shoreham Village	93.54	
South Cumberland Community	100.31	
St. Anne's Community Centre	108.16	
Surf Lodge	134.58	
Taigh Na Mara Facility	105.00	
The Cove	129.52	
Tidal View Manor	94.41	
Tideview Terrace	95.83	
Valley View Villa	101.11	
Victoria Haven Nursing Home	109.50	
Villa Acadienne	98.83	
Villa St. Joseph Du Lac	100.04	
Willow Lodge	103.34	
Windsor Elms	85.72	
Wolfville Nursing Home	96.76	
Average Per Diem	**105.39**	

% Private Pay and Residents Classified Prior to Admission

02/02/2000

Region	County	Facility	% Private Pay (2)	Classified (3)
c	Halifax	Armview Estates	19.6	n
c	Halifax	Birches	10.0	n
c	Halifax	Duncan MacMillan	12.0	n
c	Halifax	Fairview Villa	21.3	n
c	Halifax	Glades	15.4	n
c	Halifax	Melville Lodge	40.0	n
c	Halifax	Musquodoboit Valley	25.0	n
c	Halifax	Northwood Care	25.5	n
c	Halifax	Oakwood Terrace	40.5	n
c	Halifax	Ocean View Manor	17.9	y
c	Halifax	Saint Vincent's	40.6	n
c	Halifax	Scotia Nursing	13.3	n
c	Hants	Dykeland	24.5	y
c	Hants	Haliburton Place	36.7	y
c	Hants	Windsor Elms	56.9	n
e	Antigonish	R.K. MacDonald	20.8	y
e	Cape Breton	Breton Bay	10.2	y
e	Cape Breton	Cove	15.7	y
e	Cape Breton	Glace Bay Health Centre	45.8	y
e	Cape Breton	Inverary Manor	11.7	y
e	Cape Breton	MacGillivary	10.8	y
e	Cape Breton	Maple Hill	4.0	y
e	Cape Breton	Miner's Memorial	5.7	y
e	Cape Breton	New Waterford	10.0	y
e	Cape Breton	Northside Guest Home	7.8	y
e	Cape Breton	Northside Harbour View	4.8	y
e	Cape Breton	Seaview Manor	2.0	y
e	Cape Breton	Victoria Haven	0.0	y
e	Guysborough	Canso	0.0	y
e	Guysborough	MacKarchers	10.3	y
e	Guysborough	Milford Haven	16.0	y
e	Inverness	Foyer Pere Fiset	13.3	y
e	Inverness	Inverness Memorial	9.1	y
e	Inverness	Port Hawkesbury	20.0	y
e	Richmond	Richmond Villa	13.3	y
e	Richmond	St. Anne's	0.0	y
e	Victoria	Alderwood Manor	15.7	y
e	Victoria	Highland Manor	0.0	y
n	Colchester	Glenview Lodge	8.3	n
n	Colchester	Hillcrest Manor	14.3	n
n	Colchester	Willow Lodge	13.7	n
n	Cumberland	Bayview Memorial	12.5	y
n	Cumberland	East Cumberland Lodge	15.4	y

Region	County	Facility	% Private Pay (2)	Classified (3)
n	Cumberland	Gables	21.1	n
n	Cumberland	High-Crest Springhill	8.9	n
n	Cumberland	South Cumberland Hospital	14.3	y
n	Pictou	Glen Haven	13.2	y
n	Pictou	Maritime Oddfellows	22.7	n
n	Pictou	Shiretown	24.5	n
n	Pictou	Valley View Villa	15.6	y
w	Annapolis	Annapolis Royal	20.5	y
w	Annapolis	Mountain Lea Lodge	33.9	y
w	Annapolis	Northhills	20.6	y
w	Digby	Tideview Terrace	15.7	y
w	Digby	Villa Acadienne	14.3	y
w	Kings	Evergreen Home	16.5	y
w	Kings	Grandview Manor	28.8	y
w	Kings	Wolfville	48.5	n
w	Lunenburg	Harbour View Haven	38.0	y
w	Lunenburg	Hillside Pines	28.0	y
w	Lunenburg	Mahone Bay	19.3	y
w	Lunenburg	Rosedale Home	27.6	y
w	Lunenburg	Shoreham Village	24.1	y
w	Queen's	North Queens	16.7	y
w	Queen's	Queen's Manor	16.7	y
w	Shelburne	Roseway Manor	18.5	y
w	Shelburne	Surf Lodge	8.8	y
w	Yarmouth	Nakile Home	8.6	y
w	Yarmouth	Tidal View Manor	19.4	y
w	Yarmouth	Villa St Joseph du Lac	29.1	y
		Average	**20.8**	**% yes = 71.4**

Sources:

1. **Department of Health Licensing Report for Nursing Homes and Homes for the Aged- October 22, 1998 to December 2, 1999. Information for the second column "classified" was gathered via telephone surveys by DOH staff January 2000.**
2. **This column shows the % of residents who receive no Provincial Government financial assistance. These residents are mostly self-pay.**
However, some receive financial assistance from the Federal Government (e.g. Vetern Affairs Canada), the Workers' Compensation Board or other insurance plans.
3. **This column indicates whether the Nursing Home requires all applicants (private pay and publicly assisted) to be classified prior to admission.**

CONTINUING CARE SERVICE COMPONENTS AVAILABLE IN NOVA SCOTIA

The range of continuing care service options available in each province varies and terminology used to describe service options is not common across jurisdictions. Hollander and Walker (1998), on behalf of the Federal/Provincial/Territorial Ministers of Health, authored a report entitled *Report of Continuing Care Organization and Terminology* that outlines the key continuing care service components found in Canada. Through a consensus process, a set of definitions were developed for each component.

The Hollander & Walker definitions for each of the key continuing care service components are provided below. Each definition is followed by a brief statement indicating the status of the component's development in Nova Scotia. The definitions have been organized under two sections: available in Nova Scotia and partially or not available in Nova Scotia. These analysis provides an easy-to-grasp reference for those who wish to understand the scope and gaps of continuing care service components in the in the Nova Scotia system.

Available in NS

1. **Assessment and Case Management**

"A process of screening clients, conducting assessments, determining care needs, determining eligibility, making referrals to appropriate services, admitting clients into service(s) and providing for the ongoing monitoring of care requirements, including the revision of care plans, and discharge planning. ..."

The Departments of Health and Community Services are primarily responsible for this component. The involvement of two departments fragments this function. Home Care Nova Scotia provides this service to its clients, and the Department of Community Services' Case Workers provide this services to its clients as well as Nursing Home applicants.

2. **Long Term Care Residential Facilities**

"Provide care for clients who can no longer live safely at home. Residential care services provide a safe, protective, supportive environment and assistance with activities of daily living for clients who cannot remain at home due to their need for medication supervision, 24-hour surveillance, assisted meal service, professional nursing care and/or supervision. ..."

In Nova Scotia, several types of long-term care facilities are available. The Departments of Health and Community Services share responsibility for this component. The Department of Health oversees Nursing Homes (5,832 beds), while the Department of Community Services oversees licensed care facilities called Regional Rehabilitation Centers (282 beds), Adult Residential Centers (683 beds), and Residential Care Facilities (1,217 beds).

3. **Group Homes**

"Are homes or home-like residences which enable persons with physical and/or mental disabilities to increase their level of independence through a pooling of group resources. They must be able to participate in a cooperative living situation with other challenged individuals. ..."

The Department of Community Services is responsible for licensed Group Homes (289 beds). The Department also operates Community Based Options which include the following programs: Associated Families/Foster Care (≅ 55 clients), Supervised Apartments (≅ 591 clients), Community Residences (≅ 256 clients), and Small Options (≅ 865 clients).

4. Life and Social Skills for Independent Living

May provide training and support for independent living, and for social and personal development and integration, in group settings or on an individual basis.

The Department of Community Services is responsible for this component.

5. Congregate Living Residences

"Are apartment complexes which offer amenities such as emergency response, social support and shared meals."

The Department of Housing and Municipal Affairs is primarily responsible for this component. These make take the form of Enriched Housing units (251units - 40 units are not subsidized). Enriched Housing are seniors public housing units located adjacent to nursing homes. Under this arrangement, the seniors can purchase care services from the nursing home. There are also 40 units that are operated are not associated with nursing homes but maintain a 24 hour home care worker presence. The Department of Housing and Municipal Affairs also operates Seniors Apartments (7,467 public housing units). These Apartments are for people 58 years of age and older who can live independently. These tenants may receive home care services just like any other member of the public.

6. Home Care Nursing

"Provides comprehensive nursing care to people in their homes, generally by registered or psychiatric nurses. A home care nursing program coordinates a continuum of nursing services designed to support clients of all ages to remain in their homes during an acute, chronic, or terminal illness. ... Goals for home care nursing can be curative, rehabilitative, palliative, or supportive."

This component is provided through Home Care Nova Scotia, Department of Health.

7. **Homemaker Services**

Are provided to clients who require non-professional (lay) personal assistance with care needs or with essential housekeeping tasks. Personal care needs may include help with dressing, bathing, grooming, and transferring, whereas housekeeping tasks might include activities such as cleaning, laundry, meal preparation, and other household tasks. ..."

This component is provided through Home Care Nova Scotia, Department of Health.

8. **Equipment and Supplies**

"May be provided as required to maintain a person's health, eg. medical gases or assisted-breathing apparatus, and to improve the opportunities for self-care and a better quality of life, eg., wheelchairs, walkers, electronic aids, etc. Equipment may be loaned, purchased or donated."

This component is delivered by the Provincial government and non-profit agencies such as the Red Cross. The Departments of Health and Community Services provide equipment and supplies through the Social Assistance Act to those in need. Home Care Nova Scotia provides some equipment and supplies, for instance, Home Oxygen.???

9. **Meal Programs**

"Are generally voluntary community services that deliver a nutritious hot, or frozen, meal to the homebound client (Meals-on-Wheels) or bring the client to a congregate setting to have a meal (Meals-on-Wheels). ..."

In Nova Scotia, this component is provided by a variety of community based agencies.

10. **Transportation Services**

"May be provided to persons with disabilities and others with mobility related limitations to allow them to go shopping, keep appointments and attend social functions. Some vehicles are adapted for wheelchairs and other devices."

This component is provided primarily through voluntary agencies and municipal governments.

11. **Support Groups**

"May be initiated by many sources, eg., community and institutional health services, friends, families of clients, and individuals having similar needs. The groups provide peer support and foster mutual aid. Some groups may receive government subsidies."

This component is provided primarily through voluntary agencies.

12. **Volunteers**

"May provide programs of volunteer help that are utilized in addition to formal care services. Volunteer services may include, but are not limited to, friendly visiting, telephone reassurance and monitoring, doing errands and shopping, and other social and recreational activities."

There are facility based volunteer programs as well as community based voluntary agencies. Home Care Nova Scotia links makes referrals to volunteer agencies.

Partially or Not Available in Nova Scotia

1. **Adult Day Support**

"Provides personal assistance, supervision and an organized program of health, social, educational and recreational activities in a supportive group setting. Nursing, rehabilitation, and a range of other professional and ancillary services may be provided. The program is designed to maintain persons with physical and/or mental disabilities, or restore them to their optimum capacity for self-care. It can also be used to provide respite care, training and informal support to family caregivers. Adult Day Support may be provided within a residential care facility or may be provided through organizations in the community."

Adult Day Support services are operated by nursing homes, hospitals, and community based agencies such as the Victoria Order of Nurses. There are 18 programs in total.

2. **Respite Services**

"May be provided to primary caregivers to give them temporary relief or support by providing a substitute for the caregiver in the home or by providing alternate accommodation to the client in a residential setting."

There are 82 beds in nursing homes designated for short stay respite. Home Care Nova Scotia provides in-home respite care.

3. **Palliative Care**

"Is an interdisciplinary service that provides active, compassionate care to the terminally ill in their home, a hospital, or other health care facility. Palliative care is provided to individuals, and their families, where it has been determined that treatment to prolong life is no longer the primary objective."

Palliative care is provided in hospital, nursing homes, and in the home. However, the availability of services is not consistent across the province and there is no formal integrated program for service provision.

4. **Chronic Care Units/Hospitals**

"Provide care to persons who, because of chronic illness and marked functional disability, require long term institutional care but do not require all of the resources of an acute, rehabilitation or psychiatric hospital. Twenty-four hour coverage by professional nursing staff and on-call physicians is provided, as well as care by professional staff from a variety of other health and social specialties. Only people who have been properly assessed and who are under a physician's are are admitted to chronic care facilities. Care may be provided in designated Chronic Care Units in acute care hospitals or in stand alone Chronic Care Hospitals. Care requirements are typically 2.5 hours of professional nursing care per day or more."

With the exception of a less than 20 beds along the Eastern Shore, there is no provincial chronic care program. In the absence of a program, individuals with chronic care needs are served on medicine wards of hospitals or in nursing homes.

5. Assessment and Treatment Centers and Day Hospitals

"Provide short-term diagnostic, assessment and treatment services in a special unit within an acute care hospital or other health facility. These centers provide intensive short term assessment services to ensure that persons with complex physical mental and social needs are correctly assessed, diagnosed, and treated. The objective of the centers is to assist the client to achieve, regain, and maintain an optimal level of functioning and independence. Centers may have beds for short-term inpatient assessment and treatment, a day hospital service, and/or an outreach capability which permits staff to assist clients, who are in care facilities or in their homes, and their families."

The QE2 operates a geriatric assessment and treatment centre and day hospital that serves primarily the Central Region. Smaller operations are exist in Truro/Pictou/SpringHill and Antigonish. The Western Region receives some outreach services from the centre at the QE2, while such services are not available on Cape Breton Island.

6. **Community Physiotherapy and Occupational Therapy**

"Provide direct assessment, treatment, consultative and preventative services to clients in their homes to monitor, rehabilitate, or augment function, or to relieve pain. Therapists may also arrange for the necessary equipment to manage the clients' physical disabilities and may train family members to assist clients. ..."

There is no program in Nova Scotia. Home Care Nova Scotia intends to expand into this area in the future.

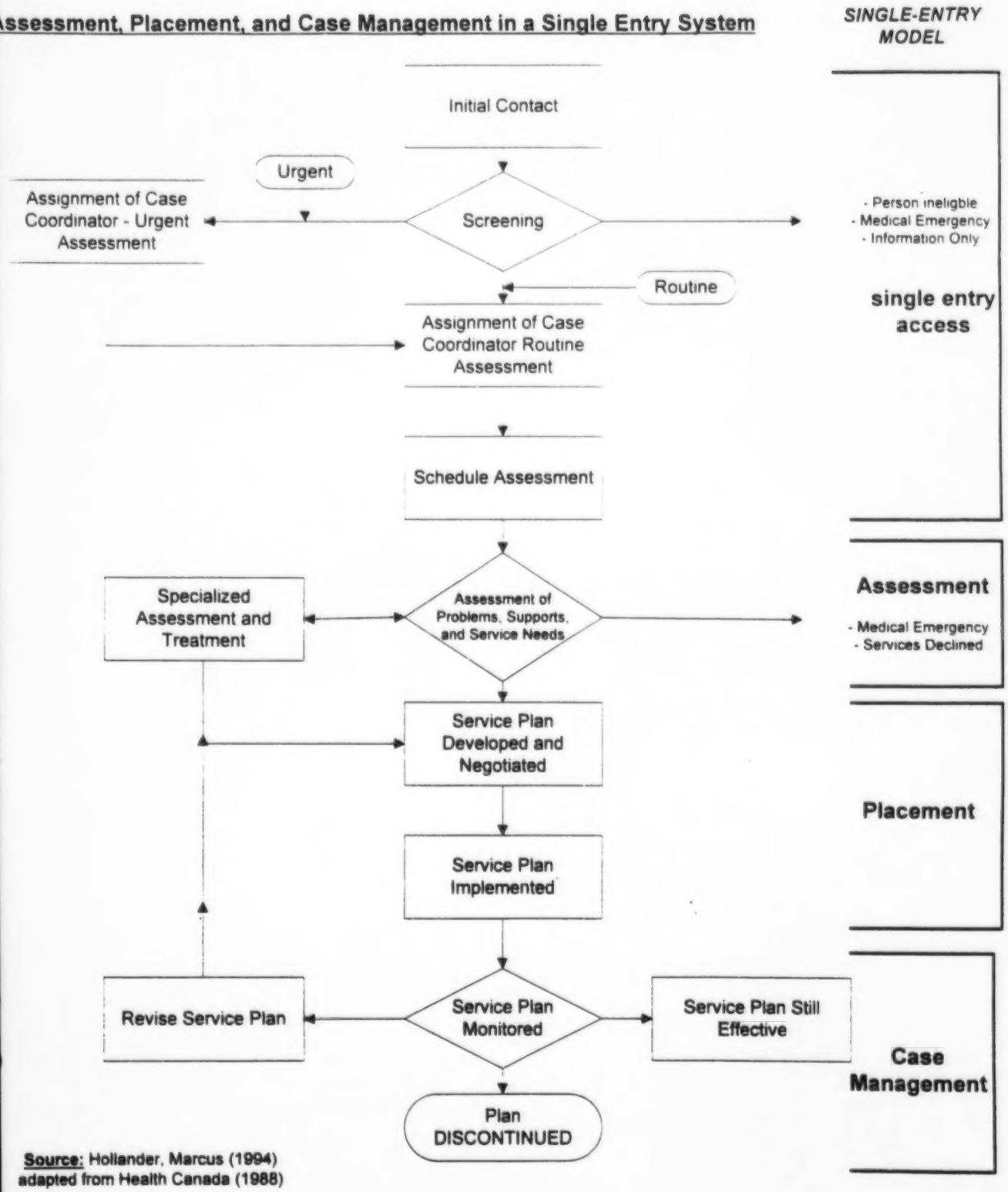
7. **Crisis Support**

"May be available in the community to give emergency assistance when existing arrangements break down, eg., illness of the spouse or caring for a disabled person, which could include

facilitation of emergency admission to institutional care, or the provision of enhanced Home Care."

In a few areas of the province, quick response programs have been developed to redirect patients from the emergency department of the hospital to home care programs. A province wide program does not exist.

Assessment, Placement, and Case Management in a Single Entry System



Source: Hollander, Marcus (1994) adapted from Health Canada (1988)